

University Hospitals Bristol NHS Foundation Trust

University Hospitals Bristol Main Site

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Outstanding 

Urgent and emergency services

Good 

Medical care (including older people's care)

Good 

Surgery

Outstanding 

Outpatients and diagnostic imaging

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected University Hospitals Bristol Main Site as part of our comprehensive inspections programme of all NHS acute trusts.

The inspection was announced and took place between 22 and 24 November 2016. We also inspected the hospital on an unannounced basis on 1 December 2016.

We rated the hospital as outstanding overall. The effective and well led key questions were rated as outstanding; safety and caring was rated as good; and the responsiveness of the hospital was rated as requires improvement.

Our key findings were as follows:

Safe:

- We rated safety in the hospital as good, and found safety was good in all the services we inspected.
- Openness and transparency about safety was embedded in the services we inspected. There was a positive safety culture with good staff involvement. Learning opportunities were identified and shared with staff within their own area and across the trust to support improved safety, and led to changes in practice
- When things went wrong patients were provided with a timely apology and support. The majority of staff understood their responsibilities under the Duty of Candour requirement and could provide examples when they had been used.
- Innovation was encouraged, such as SHINE in the emergency department, which provided staff with a simple checklist to ensure patient-safety based actions were completed. Since its introduction there had been no incidents of a deteriorating patient not being identified and then managed.
- Wards and departments appeared visibly clean. A thorough cleaning programme was in place across the hospital and staff were observed using personal protective equipment to prevent infection. Staff were seen to use hand sanitising gel prior to providing care and treatment to patients.
- Medicines managed safely and effectively in the services we inspected. Learning was evidenced from incidents relating to medicines, and medicines administration records were fully completed.
- Nurse and medical staffing levels met national and local guidelines and planned to ensure safe care, and agency staff were only used when required to cover increased demand and vacancies. There were effective handovers and shift changes, to ensure staff can manage risks to patients who use services.
- Consultant cover in the emergency department did not meet the 16-hours on-site standard and was reduced significantly at weekends. However, junior doctors felt well supported and both the local management team and trust executives were aware of this concern and had actions ongoing to improve the levels of cover.
- Staff understood their safeguarding responsibilities. Staff were aware of local procedures and knew what to do if they had a concern. In surgery we found examples where staff had taken steps to prevent abuse from occurring and responding to signs of abuse by working with the safeguarding team and local authority to ensure patients were protected. There was lack of clarity around the correct processes to safeguard children between the ages of 16 and 18 years in the surgical trauma assessment unit. There were concerns in this unit around the levels of safeguarding training provided to staff working overnight.
- Staff carried out comprehensive risk assessments for patients and developed management plans to ensure risks to patients' safety were monitored and maintained. The World Health Organisation surgical safety checklist was utilised effectively to keep patients safe. However, the environment for patients on the oncology ward presented a potential risk to the safety of patients who may be confused or could not maintain their own safety.
- Systems to ensure patients' information was kept safe were not always implemented. Records were found to not be stored securely which could cause a potential breach of patients' confidentiality in the emergency department, outpatients departments and on medical wards.

Summary of findings

- Mandatory training compliance for nursing and medical staff across the services we inspected were below the hospitals target, including fire, resuscitation and safeguarding training for medical staff. Receptionists in the emergency department had not received any training or guidance to help them identify potentially seriously unwell patients.

Effective:

- We rated the effectiveness of services within the hospital as outstanding. Urgent and emergency services were rated as outstanding, and medical care and surgery were rated as good. We do not currently rate the effectiveness of outpatients and diagnostic imaging.
- Patients had comprehensive assessments of their needs, which include consideration of clinical needs, including both mental and physical health and wellbeing, nutrition and hydration needs.
- We found there was good multidisciplinary working and people received care from a range of different staff, teams or services, in a coordinated way. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Patients' care and treatment was planned in line with current evidence based guidance. Clinical care pathways were developed in accordance with national guidelines. Trust policies included reference to NICE guidance and other national strategies. However, the diagnostic imaging service did not always ensure it met best practice clinical guidance for report turnaround time for medical staff requesting diagnostic imaging to be carried out.
- Patients received care from different teams who worked together to coordinate care. We observed board rounds taking place on wards, which demonstrated effective multi-disciplinary working. For some wards complex discharges were daily occurrences. A multidisciplinary audit programme was in place and actively used by staff to encourage and monitor improved outcomes. There were links with GPs and community providers to ensure safe patient discharge.
- The hospital achieved good patient outcomes and delivered effective care in the emergency department and medical wards. A programme of local and national audits was used to monitor care and treatment. Some areas showed improvements, including the national stroke audit. In outpatient departments clinics were benchmarked against each other and actions put in place to improve outcomes. Outcomes for people who used the surgical services were mixed. The trust performed well in the bowel cancer audit and the oesophago-gastric cancer national audit and had an improving picture for the national emergency laparotomy audit. However, results were not always in line with the national scores. For example, the trust was performing worse than the national average in some elements of the hip fracture audit, although, the service provided at this trust was relatively small compared to other trusts. Despite this, mortality rates were better than the England average in all audits we reviewed.
- Innovative approaches were used to deliver care. This included simple solutions such as a touchscreen guideline system in the emergency department resuscitation area, and the close working relationships with external partners to deliver alternative care pathways and admission avoidance programmes. The SHINE patient safety assessment tool had driven significant improvements and clearly demonstrated improved outcomes.
- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- Not all staff had received an appraisal in the last year, with particular low compliance in the ancillary staff group. Without an appraisal, learning needs may not be identified and a plan put in place to support staff to develop their practice.

Caring:

- Overall, caring within the hospital was rated as good. Surgery was rated as outstanding for caring and all other services inspected were rated as good.

Summary of findings

- People we spoke with praised the staff for their kindness and compassion. Patients told us they had been treated with dignity and respect at all times by staff who were respectful and caring.
- Staff often went out of their way to meet the emotional and physical needs of patients. It was clear they had taken the time to get to know and understand their patients. Staff took the time to ensure patients were comfortable, responding compassionately to patients in pain or distress and giving reassurance and support.
- We observed doctors and nurses introducing themselves when they met patients and their families for the first time. Patients in the emergency department were addressed by their preferred name. Patients and those close to them were treated as partners in their care and supported to make informed decisions about their care and treatment. We saw examples where relatives and carers were included as part of the care provided for both physical and emotional wellbeing. In outpatient departments staff talked about patients compassionately with knowledge of their circumstances and those of their families. Relatives were encouraged to be involved in care as much as they wanted to be, while patients were encouraged to be as independent as possible.
- We saw staff from all groups assisting patients and others who were confused or lost in the emergency department in a helpful and supportive manner. One doctor was seen helping a patient to the toilet.
- Staff in the emergency department had received lots of positive feedback about the compassionate care provided in the form of cards and letters, and these were displayed in the staff room.
- Patients' privacy and dignity was respected and staff sought permission before carrying out care and treatment in all the services we inspected. In the emergency department staff used curtains around the bed spaces to provide privacy when assessing and treating patients, and ensured patients' dignity was maintained when curtains were opened. Patients in the corridor, however, did not have the same provision to ensure their privacy. Staff did their best to ensure confidentiality and privacy in the corridor by keeping conversations as quiet as possible, but because of the close proximity of other patients and relatives conversations could still be overheard.

Responsive:

- Overall, improvements were required to ensure that services within the hospital were responsive to patients' needs. We rated the responsiveness of services within the hospital as requires improvement. Urgent and emergency services were rated as requires improvement. However, surgical services, medical care and outpatients and diagnostic imaging were rated as good.
- Access and flow was an issue within the hospital. The hospital was consistently failing to meet the national standard which requires 95% of patients to be discharged, admitted or transferred within four hours of their arrival at the emergency department. The emergency department suffered from regular crowding, and this was cited as the department's greatest risk. Patients spent longer in the emergency department compared to the England average.
- The emergency department and the trust were working closely with commissioners and partners to address system-wide flow issues and introduce innovative methods to improve patient flow.
- Waiting times, delays and cancellations were minimal and managed.
- Referral to treatment times for different specialties within the medicine division were not all within the England standards. Within surgery referral to treatment standards were being met 92% of the time. Where there had been a slip in performance there were clear actions to address these which had been proven to be effective. In the outpatients departments the overall referral to treatment standard on average was slightly worse than the national average.
- Processes to ensure patients who were medically fit to leave the hospital were not always timely. However, in the majority of cases, reasons for discharge delays were not attributable to the hospital.
- We found that medical and surgical services were planned and delivered in a way that met the needs of local patients. The hospital offered choice and flexibility to patients and provided continuity of care. New clinics, services and virtual facilities were implemented, to ensure services met patients' needs. However, sometimes incurred delays due to issues elsewhere.

Summary of findings

- The medical wards were creative to ensure patient flow through the hospital was maintained and was responsive to the ever-changing demand. There was a constant oversight by senior staff, of how different departments were managing flow, to ensure staff across all areas of the hospital prioritised patient safety, whilst maintaining the flow of patients through the hospital.
- The flow of patients through the medical division was monitored and actions taken to minimise the numbers of patients being cared for on wards other than those related to their medical condition/specialty. These patients were known as medical outliers. The hospital ensured outlying patients received the care and input from nursing and medical staff, relevant to their medical condition/specialty.
- The radiology department was slightly below the national standard of 90% of patients referred by the cancer referral process to be seen within two weeks. However; the diagnostic and imaging department was above the national average for the percentage of patients seen within six weeks.
- Patients were not always able to locate the outpatients and diagnostic imaging departments because they were not clearly signposted. A wide selection of information leaflets were available to patients; however, they were not available in other languages.
- The parking facilities did not always meet the demand leaving patients unable to find a space in a timely manner.
- There was good support for patients living with dementia or learning difficulties, and translation services were available for patients whose first language was not English. Reasonable adjustments were made for people living with dementia or with learning difficulties including use of the 'this is me' document and access to activities for stimulation. There were access to dedicated teams for dementia, learning disabilities and psychology which were always available.
- In response to the last inspection and feedback from patients, each outpatient department had introduced waiting time boards which displayed the waiting times for each clinic for that day.

Well led:

- We rated the well led domain as outstanding. Urgent and emergency services and surgery were rated as outstanding; and medical care and outpatients and diagnostic imaging were rated as good.
- The leadership, governance and culture promoted the delivery of high-quality person centred care. There was a clear statement of vision and values within the trust which was driven by quality and safety. We found clear statements of vision and values for medical care, surgery, and outpatients and diagnostic imaging, which were driven by safety and quality. The strategies and supporting objectives were stretching, challenging and innovative whilst remaining achievable. The emergency department strategy had not yet been drafted and agreed, although there were programmes of work underway which showed progress towards achieving the department's vision.
- Staff understood the vision and strategy and their role in delivering it. They were proud to work for the hospital and patient focused. Staff demonstrated a kind culture, both to patients and relatives, and to each other.
- Governance structures were complex to follow. However, the board and other levels of governance within the hospital functioned effectively and interacted well. Staff told us their responsibilities were clear and quality, performance and risks were understood and managed. Risks were escalated when needed and the information communicated to the hospital board flowed well. Processes were in place to monitor, address and manage current and future risk. Performance issues and concerns were escalated to the relevant committees and board. There was a continued focus and drive to improve safety and quality through excellent governance and leadership.
- Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture and to motivate staff to succeed. Leaders understood the challenges to good quality care within and outside the organisation, and there were collaborative relationships with stakeholders.
- Staff felt leadership was good and divisional lead staff were accessible. Staff told us they felt supported and heard, and there was a collective culture of openness to drive quality and improvement. Leaders and staff demonstrated the participation and involvement of patients who used the service was important to them.

Summary of findings

- Staff were proud of the organisation as a place to work and spoke highly of the culture. There were high levels of constructive engagement with staff. Where there had been a poor culture identified innovative and effective actions were put into place to resolve them.
- Innovative approaches were encouraged and supported, and these had a clear focus on patient safety, quality and performance, from staff led forums to improve the efficiency of work streams to research in pioneering research techniques. Changes were monitored effectively to evidence the improvements to patient care the changes had.
- Leaders demonstrated a drive for continuous learning and improvement through the ongoing evaluation and monitoring of the service and by delivering projects and innovative developments aligned to this.
- The management and governance of current performance of staff mandatory training did not ensure all staff were fully training. For medical staff, this included fire, safeguarding and resuscitation training.
- The medical division had recognised a risk in the acute oncology service at night, concerning both staffing levels and a lack of suitably skilled triage staff. However, sufficient action was required to minimise the risk to patients in both the service provision and staffing provision.

We saw several areas of outstanding practice including:

- In times of crowding the emergency department was able to call upon pre-identified nursing staff from the wards to work in the department. This enabled nurses to be released to safely manage patients queueing in the corridor.
- The audit programme in the emergency department was comprehensive, all-inclusive and had a clear patient safety and quality focus.
- New starters in the emergency department received a comprehensive, structured induction and orientation programme, overseen by a clinical nurse educator and practice development nurse. This provided new staff with an exceptionally good understanding of their role in the department and ensured they were able to perform their role safely and effectively.
- In the emergency department the commitment from all staff to cleaning equipment was commendable.
- The comprehensive register of equipment in the emergency department and associated competencies were exceptional.
- Staff in the teenagers and young adult cancer service continually developed the service, and sought funding and support from charities and organisations, in order to make demonstrable improvements to the quality of the service and to the lives of patients diagnosed with cancer. They had worked collaboratively on a number of initiatives. One such project spanned a five year period ending May 2015 for which some of the initiatives were ongoing. The project involved input from patients, their families and social networks, and healthcare professionals involved in their care. It focused on key areas which included: psychological support, physical wellbeing, work/employment, and the needs of those in a patients' network.
- The use of technology and engagement techniques to have a positive influence on the culture of an area within the hospital. There were clear defined improvements in the last 12 months in Hey Groves Theatres.
- The governance processes within the division to ensure risks and performance were managed.
- The challenging objectives in the strategy and how they are used to proactively develop the quality and the safety of the service.
- The use of innovation and research to improve patient outcomes and reduce length of stay. The use of a discrete flagging system to highlight those patients who had additional needs. In particular those patients who were diabetic or required transport to ensure they were offered food and drink.
- The introduction of IMAS modelling in radiology to assess and meet future demand and capacity.
- The use of in-house staff to maintain and repair radiology equipment to reduce equipment down time and expenses.
- The introduction of a drop in chest pain clinic to improve patient attendance.

However, there were also areas of poor practice where the trust needs to make improvements. Importantly, the trust must:

Summary of findings

- Ensure all medicines are stored correctly in medical wards, particularly those which were observed in dirty utility rooms.
- Ensure records in the medical wards and in outpatient departments are stored securely to prevent unauthorised access and to protect patient confidentiality.
- Ensure all staff are up to date with mandatory training.
- Ensure non-ionising radiation premises in particular Magnetic Resonance Imaging (MRI) scanners restrict access.

In addition the trust should:

- Ensure chemicals are stored securely at all times in the emergency department and on medical wards.
- Ensure checks of the equipment in the emergency department's resuscitation area are recorded consistently.
- Ensure patients in the emergency department have access to call bells at all times.
- Ensure reception staff are able to recognise patients who attend the emergency department with serious conditions and need urgent referral to the triage nurse and provide a formalised process for summoning help.
- Continue working towards providing 16-hours on-site consultant cover in the emergency department, and increase consultant cover at the weekend.
- Ensure the emergency department is accessible to wheelchair users and the layout of the reception desk allows staff to interact with wheelchair users whilst sat at the desk.
- Ensure the emergency department develops and formalises its vision and strategy.
- Ensure staff in the emergency department are up-to-date with their mandatory training, including safeguarding adults and children.
- Work with commissioners and the local mental health service provider to ensure mental health patients arriving at the emergency department receive the care they require in a timely manner.
- Ensure all staff working in the emergency department and medical staff receive an annual appraisal.
- Ensure clear signage and equipment is in place for staff, patients and visitors to wash their hands when entering a medical ward area.
- Ensure the environment in the oncology department and ward keeps patients safe and comfortable, especially for patients who may be confused or cannot maintain their own safety.
- Ensure access to the staff room on the medical assessment does not allow access to unauthorised people.
- Take remedial maintenance action to ensure the heating system on ward D703 maintains a suitable and safe temperature for staff and patients.
- Ensure staff have a greater understanding and awareness of the intercom system on the Hepatology ward, to ensure safe and prompt access to the ward and confidentiality of patient information.
- Ensure medical doctors' inductions are undertaken in scheduled blocks and planned so doctors do not start work on the wards without an induction.
- Ensure clear signage and equipment is in place on medical wards to advise staff, patients and visitors to wash their hands when entering a ward area.
- Ensure delays in the provision of take home medicines do not delay patients.
- Ensure medical records are legibly and fully completed. This includes patient risk assessments.
- Audit records in the cardiac catheter laboratory to ensure they are fully compliant with the World Health Organisation surgical safety checklist for all surgical procedures.
- Address the risk in the acute oncology service where patients may be placed at risk by reduced staffing levels at night due to admissions of emergency oncology patients. There should be suitably skilled staff in place at night to ensure safe triage advice is given to patients accessing the emergency oncology service. Whilst the trust recognised these risks, sufficient action should be taken to minimise the risk to patients in both the service provision and staffing provision.
- Ensure pain audits are established to monitor if pain was managed effectively for patients with an ability to express their pain.

Summary of findings

- Continue to monitor staff's use of the Abbey Pain Scale to ensure patients with cognitive impairment in the specialised services division have an effective tool to assess their pain needs.
- Continue to ensure all efforts be made to maintain flow through the hospital and patients be nursed on the correct wards to meet their needs.
- Reduce the risk on the hepatology ward in relation to lone working practices, when accompanying patients off the ward at night to smoke.
- Improve the level of safeguarding training for staff working overnight in the surgical trauma assessment unit.
- Improve compliance for mandatory training in surgical areas.
- Improve patient outcomes to bring them in line with the national average for the hip fracture audit and improve the National Emergency Laparotomy Audit.
- Ensure patients within all of the diagnostic imaging waiting rooms can be monitored by staff.
- Monitor the World Health Organisation (WHO) Surgical Safety Checklist is always used in the appropriate area as a checklist when carrying out non-surgical interventional radiology.
- Provide leaflets within outpatient departments are available in different languages
- Check local and national diagnostic reference levels (DRLs) are on display as stated in Regulation 4(3)(c) of IR(ME)R 2000 and IR(ME) amendment regulations 2006 and 2011.
- Make improvements on the follow up backlog waiting list to meet people's needs and minimise risk and harm caused to patients through excessive waits on follow up of outpatient appointments and the reporting of images.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

We rated this service as good because:

- There was a multidisciplinary audit programme in place which was actively used by staff to encourage and monitor improved outcomes.
- Innovative approaches were being used to deliver quality care. In particular a new patient safety assessment tool, known as SHINE, had driven significant improvements and clearly demonstrated improved outcomes.
- There was a strong multidisciplinary approach to patient care and this included staff within and external to the department, including partner organisations.
- There was a real focus on staff learning and development. Staff were supported and sponsored by the department and the trust to complete additional relevant qualifications.
- Staff demonstrated a clear understanding of consent and best interest decision practices and records evidenced these were being followed.
- There was a continued focus and drive to improve safety and quality through excellent governance and leadership.
- Leaders were respected by their teams and truly encouraged a supportive, open and honest culture amongst all staff.
- Innovative approaches were encouraged and supported, and these had a clear focus on patient safety, quality and performance.
- There was an extremely positive safety culture, with all staff taking an interest and personal responsibility with regard to patient safety.
- Learning opportunities were identified and these were actively shared with staff to support improved safety. The use of simulation training to further embed learning was an excellent tool.
- Medicines were managed safely and securely. Incidents relating to double administrations had led to new stickers being implemented to highlight pre-hospital medicines administration to staff.

Summary of findings

- Nursing staffing levels met national guidelines and additional nurses were called upon from the wards to support the department in times of crowding.
- People were treated with dignity and respect and staff were mindful of confidentiality and privacy.
- Staff took time to ensure patients and their relatives understood their care, diagnosis and treatment plans.
- The emergency department and the trust were working closely with commissioners and partners to address system-wide flow issues and introduce innovative methods to improve patient flow.

However:

- The trust was consistently failing to meet the national standard which requires 95% of patients to be discharged, admitted or transferred within four hours of their arrival at the emergency department.
- The emergency department suffered from regular crowding, and this was cited as the department's greatest risk. This was on the corporate risk register.
- Wheelchair users and patients with mental health conditions were not having their needs met.
- Patient privacy and confidentiality could not be maintained in the corridor when the department was crowded.
- Not all staff had received an appraisal in the last year, with particular low compliance in the ancillary staff group.
- Consultant cover did not meet the 16-hours on-site standard and was reduced significantly at weekends. However, junior doctors felt well supported and both the local management team and trust executives were aware of this concern and had actions ongoing to improve the levels of cover.
- Receptionists did not receive any training or guidance to help them identify potentially seriously unwell patients and there was no formalised procedure for calling for help in the event of a patient deteriorating in the waiting room. However, while this presented a risk to patients awaiting triage, no incidents of harm had been reported.

Summary of findings

Medical care (including older people's care)

Good



We rated this service as good because:

- There was a good incident reporting culture and staff were encouraged to report incidents. Learning from incidents had led to changes in ward practice.
- Safety was monitored and actions taken to improve safety.
- Staffing levels were in line with the hospital's staffing measurement tools.
- Feedback from patients and those close to them was positive. Patients' emotional and social needs were valued and this was demonstrated in the way staff cared for patients.
- The service was flexible and creative to ensure flow was maintained. The systems put in place to support the patients on outlying wards ensured they were seen by the right medical team every day, and their care was always overseen by the medical team.
- Work had taken place to deliver services that met the needs of patients living with dementia.
- Patients' care and treatment was planned in line with current evidence based guidance.
- Patients had comprehensive assessments of their needs. Patients had their pain assessed regularly and managed promptly. Their nutrition and hydration was assessed and monitored.
- A programme of local and national audits was used to monitor care and treatment was being provided in accordance with national guidelines. Some areas showed improvement, including the national stroke audit.
- Learning needs of staff were identified and training put in place to meet those needs.
- Patients received care from different teams who worked together to coordinate care. There were links with GP's and community providers to ensure safe patient discharge.
- When patients who needed specialist community support were discharged, effective links were made with community services.
- Whilst care was provided seven days a week, ward rounds by medical staff did not take place every day. However, access to medical care was always available.
- Discharge delays, transfers and bed moves were all monitored to ensure they did not negatively impact on patients.

Summary of findings

- Complaints were handled in accordance with trust policy, and improvements were made in response to complaints.
- There was a clear, overarching statement of vision and values for the medicine service, which was driven by safety and quality. Staff understood the vision and strategy and their role in delivering it.
- Risks were escalated when needed and the information communicated to the hospital board flowed well. Processes were in place to monitor, address and manage current and future risk.
- Leaders understood the challenges to good quality care within and outside the organisation, and there were collaborative relationships with stakeholders.
- Staff felt leadership was good and divisional lead staff were accessible. Leaders and staff demonstrated the involvement of people who used the service was important to them.
- The hospital had forged strong links and worked closely with the voluntary sector.
- Leaders demonstrated a drive for continuous learning and improvement through the ongoing evaluation and monitoring of the service and by delivering projects and innovative developments.

However:

- Systems were not always reliable to keep patients' information safe. Records were consistently seen to not be stored securely.
- Not all medical staff had completed mandatory training in line with the trust's targets.
- Doctor induction was undertaken in scheduled blocks. Should doctors start work in between those blocks, they may work for a period of time without induction.
- There were gaps in information being monitored in specific areas of care, such as pain audits to establish if pain was managed effectively. The cardiac catheter laboratory used a World Health Organisation surgical safety checklist for all surgical procedures. However, these records were not audited to ensure they were all fully completed.
- Not all staff had received an appraisal in the last year. Without an appraisal, learning needs may not be identified and a plan put in place to support staff to develop their practice.

Summary of findings

- The management of risk did not protect staff on the hepatology ward. This related specifically to lone working practices when accompanying patients off the ward at night who wanted to smoke.
- The division had recognised a risk in the acute oncology service at night, concerning both staffing levels and a lack of suitably skilled triage staff. However, further action was required to minimise the risk to patients in both the service provision and staffing provision.

Surgery

Outstanding



We rated this service as outstanding because:

- There was a good culture of incident identification, reporting, investigation, and sharing of learning throughout the surgical division. There were many examples shared with inspectors of learning from incidents both in their own area and from the wider trust.
- Staffing levels were good with only occasional use of agency staff. Where there were shortages of staff there was a quick response to rectify this. This resulted in safe staff management and handover from staff to manage risks.
- Risks were managed and responded to effectively both on the wards and in theatre. Learning from a never event was fully integrated into the surgical safety checklist. On the wards we saw comprehensive risk assessments, which included physical and mental health, to ensure the safe care and treatment of patients.
- Staff worked effectively together as a multidisciplinary team and worked together in a coordinated way for the patients best interests. This included working between teams and services.
- Mortality rates were consistently better than the national average in all the audits we looked at.
- Feedback from patients and their families was almost entirely positive. Patients we met spoke positively of the service they received and of the compassion, kindness and caring of all staff. Staff ensured patients experienced dignified and respectful care.
- Although slightly limited, reasonable adjustments were made for patients living with dementia or with learning difficulties including use of the 'this is me' document and patient access to activities.

Summary of findings

- Leadership in the trusts surgical services was enthusiastic and staff were motivated to succeed. A strong governance structure aided managers to proactively review performance and risks and were reviewed to reflect best practice.
- We saw an innovative method of engaging staff through the use of the 'Happy App' and proactive engagement with staff. We found because of this the culture of engagement had developed to be positive. Staff were proud to work at the hospital.

However:

- Not all staff within the surgical service had received recent mandatory training to keep patients safe. There were a number of staff who had not completed all of the required training for resuscitation, safeguarding, fire, manual handling and infection control.
- The service was planned and delivered in a way which met patient's needs. However, some patients had long waiting times to have their surgical procedure due to a high level of medical outliers on surgical wards and staff shortages in some specialties. This was particularly apparent in the cleft palate service and the dental service.

Outpatients and diagnostic imaging

Good



We rated this service to be good because:

- There was a good incident reporting culture and openness and transparency were encouraged. Lessons learnt were shared in both outpatients and diagnostic imaging to make sure action was taken to improve not just the affected service.
- There were clearly defined systems and processes to keep people safe and safeguarded from abuse. All staff we spoke with had a good awareness of safeguarding legislation and what to do if they had any concerns.
- People's care and treatment in both outpatients and diagnostic imaging was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw evidence of audit to ensure that practice was monitored ensuring consistency

Summary of findings

- Feedback from patients and relatives had been consistently positive. They praised the way the staff really understood their needs and involved their family in their care. Patients were treated as individuals.
- We found although people were waiting too long for appointments, there were innovative approaches to the appointment booking systems and the management of the capacity and demand of outpatient's and diagnostic imaging clinics.
- In response to the last inspection and feedback from patients, each outpatient department had introduced waiting time boards which displayed the waiting times for each clinic for that day.
- Services were planned and delivered in a way that met the needs of the local population and took into account patient choice.
- There was a clear statement of vision and values, driven by quality and safety. It was translated into a credible strategy for outpatients with defined objectives that were regularly reviewed and relevant.
- Staff and patients were engaged in how care was delivered. Staff felt as if they were active contributors to how the service was developed.

However:

- Some medical records were not being stored securely in outpatient departments.
- There was a backlog of appointments and high levels of referrals meaning people were not able to access the services for assessment, diagnosis or treatment when they needed.
- We found doors to the MRI scanners were unlocked and were accessible to patients in the main waiting area.

University Hospitals Bristol Main Site

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Outpatients & Diagnostic Imaging

Detailed findings

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Background to University Hospitals Bristol Main Site

University Hospitals Bristol NHS Foundation Trust comprises eight hospitals and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in June 2008.

The trust had 899 beds and employed 7,745 full time equivalent staff. In the financial year 2015/16, the trust had an income of £599.2 million and costs of £596.7 million, meaning it had a surplus of £3.5million for the financial year. This was the 13th successive year of reported surplus for the trust. The trust predicted it would have a surplus of £16million in 2016/17.

The trust provided services to three distinct populations. Acute and emergency services were provided to the local population of around 450,000 in south and central Bristol. Specialist regional services were provided across the region from Cornwall to Gloucestershire. Specialist services were also provided across the whole of the South West, South Wales and beyond.

The 2015 Indices of Deprivation showed that Bristol was the 77th most deprived local authority out of 326 local authorities. Life expectancy for men, at 78.4 years, was slightly lower than the England average of 79.5 years. Life expectancy for women, at 82.9 years, was very slightly lower than the England average of 83.2 years. Bristol was significantly worse than the England average for the proportion of children living in poverty, levels of violent crime, and educational attainment. However, Bristol was better than the national average for England for the

proportion of children living in households with long-term unemployment. There were significant variations in levels of deprivation within the city of Bristol and there were areas of prosperity within the city and the immediate surrounding area. Census information showed that 16% of Bristol's population was non-white, with 6% declaring their ethnic origin as Black, 5.5% as Asian and 3.6% as mixed race.

This inspection was a follow up to our inspection in September 2014, when the trust was rated as requires improvement overall. We focused this inspection on services rated as requires improvement: surgery; medical care; and outpatients and diagnostics. We also inspected urgent and emergency care, although it was rated as good in the inspection in 2014, because national problems in accident and emergency departments and frequent ambulance queues at the Bristol Royal Infirmary were a cause for concern. We inspected the following hospitals as part of this inspection:

- Bristol Royal Infirmary;
- Bristol Heart Institute;
- Bristol Oncology and Haematology Centre;
- Bristol Eye Hospital;
- University of Bristol School of Oral & Dental Sciences.

Our inspection was carried out in two parts: the announced visit, which took place on 22, 23, and 24 November 2016; and the unannounced visit, which took place on 1 December 2016.

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Andrew Welch, Medical Director, Newcastle Upon Tyne Hospitals NHS Foundation Trust

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists including: accident and emergency nurse; accident and emergency doctor; medical nurse team leader; medical doctor; theatre nurse specialist, surgical doctor; surgery nurse team leader; medicine nurse; outpatients nurse team leader; radiographer; two experts by experience and a board level director.

How we carried out this inspection

We carried out the announced part of our inspection between 22 and 24 November 2016 and returned to visit some wards and departments unannounced on 1 December 2016.

During the inspection we visited a range of wards and departments within the hospital and spoke with clinical and non-clinical staff, patients, and relatives. We held focus groups to meet with groups of staff and managers.

Prior to the inspection we obtained feedback and overviews of the trust performance from local Clinical Commissioning Groups and NHS Improvement.

We reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust prior to our inspection. We also reviewed feedback people provided via the CQC website.

Facts and data about University Hospitals Bristol Main Site

University Hospitals Bristol NHS Foundation Trust comprises eight hospitals and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in June 2008.

The trust had 899 beds and employed 7,745 full time equivalent staff. In the financial year 2015/16, the trust had an income of £599.2 million and costs of £596.7 million, meaning it had a surplus of £3.5million for the financial year. This was the 13th successive year of reported surplus for the trust. The trust predicted it would have a surplus of £16million in 2016/17.

The trust provided services to three distinct populations. Acute and emergency services were provided to the local population of around 450,000 in south and central Bristol. Specialist regional services were provided across the region from Cornwall to Gloucestershire, into South Wales and beyond.

Between August 2015 and August 2016 there were 129,694 attendances at the emergency department.

Between September 2015 and August 2016 there were 139,486 inpatient admissions, and between July 2015 and June 2016 there were 712,591 outpatient appointments.

The trust had a stable board, with the most recent executive appointments being the director of strategy and transformation in 2016. The chief executive had been in post since 2010. The eight non-executive directors had also been appointed with most having been in post for at least three years. At the time of our inspection the chief executive was leading the work for the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan.

Inspection History:

This is the twelfth inspection of the trust since it was registered with the commission in 2010. In September 2014 we carried out an announced comprehensive review of the trust and all locations, and closed down all outstanding compliance actions. We rated the trust as requires improvement overall. Urgent and emergency

Detailed findings









care, critical care, maternity and family planning, services for children and young people, and end of life care were all rated as good. Medical care, surgery, and outpatients and diagnostics were rated as requires improvement.

Previous inspections include:







- January 2014: Dementia themed inspection
- November 2013: Responsive inspection at the Bristol Royal Hospital for Children
- April 2013: Follow up inspection
- September 2012: Responsive inspection
- May 2012: Responsive inspection
- March 2012: Special review of termination of pregnancy procedures at the Central Health Clinic

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	 Outstanding	Good	Requires improvement	 Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	 Outstanding	Good	 Outstanding	 Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	 Outstanding	Good	Requires improvement	 Outstanding	 Outstanding

Urgent and emergency services

Safe	Good	
Effective	Outstanding	
Caring	Good	
Responsive	Requires improvement	
Well-led	Outstanding	
Overall	Good	

Information about the service

University Hospitals Bristol NHS Foundation Trust had three emergency departments providing urgent and emergency care for people in central, south and north-west Bristol. These were the Bristol Royal Infirmary, Bristol Royal Hospital for Children, and Bristol Eye Hospital. In 2015/16 the three emergency departments saw 127,570 patients. This averaged 2,453 attendances a week, or 350 attendances a day.

We last inspected the urgent and emergency services provided by the hospital trust in September 2014. At that inspection we visited all three emergency departments and rated the service as good overall, with responsiveness being rated as requiring improvement and effectiveness not being rated.

For this inspection we reviewed and rated all five domains, but only visited the Bristol Royal Infirmary.

The emergency department at the Bristol Royal Infirmary included a resuscitation area with six patient spaces, a major injury and illness area with 11 patient bed spaces, a minor injury and illness area with seven assessment and treatment cubicles, and an observation unit with eight patient bed spaces. The department was a trauma unit. This meant the unit could treat trauma patients, but would transfer major trauma cases to the local major trauma centre.

Between April and August 2016 the Bristol Royal Infirmary emergency department had seen 26,070 patients, averaging 1,303 attendances a week, or 186 attendances a day.

We inspected the emergency department as part of an announced follow-up inspection on 22, 23 and 24 November 2016. We also carried out an unannounced inspection on 1 December 2016.

Urgent and emergency services

Summary of findings

We rated this service as good because:

- There was a multidisciplinary audit programme in place which was actively used by staff to encourage and monitor improved outcomes.
- Innovative approaches were being used to deliver quality care. In particular a new patient safety assessment tool, known as SHINE, had driven significant improvements and clearly demonstrated improved outcomes.
- There was a strong multidisciplinary approach to patient care and this included staff within and external to the department, including partner organisations.
- There was a real focus on staff learning and development. Staff were supported and sponsored by the department and the trust to complete additional relevant qualifications.
- Staff demonstrated a clear understanding of consent and best interest decision practices and records evidenced these were being followed.
- There was a continued focus and drive to improve safety and quality through excellent governance and leadership.
- Leaders were respected by their teams and truly encouraged a supportive, open and honest culture amongst all staff.
- Innovative approaches were encouraged and supported, and these had a clear focus on patient safety, quality and performance.
- There was an extremely positive safety culture, with all staff taking an interest and personal responsibility with regard to patient safety.
- Learning opportunities were identified and these were actively shared with staff to support improved safety. The use of simulation training to further embed learning was an excellent tool.
- Medicines were managed safely and securely. Incidents relating to double administrations had led to new stickers being implemented to highlight pre-hospital medicines administration to staff.
- Nursing staffing levels met national guidelines and additional nurses were called upon from the wards to support the department in times of crowding.

- People were treated with dignity and respect and staff were mindful of confidentiality and privacy.
- Staff took time to ensure patients and their relatives understood their care, diagnosis and treatment plans.
- The emergency department and the trust were working closely with commissioners and partners to address system-wide flow issues and introduce innovative methods to improve patient flow.

However:

- The trust was consistently failing to meet the national standard which requires 95% of patients to be discharged, admitted or transferred within four hours of their arrival at the emergency department.
- The emergency department suffered from regular crowding, and this was cited as the department's greatest risk. This was on the corporate risk register.
- Wheelchair users and patients with mental health conditions were not having their needs met.
- Patient privacy and confidentiality could not be maintained in the corridor when the department was crowded.
- Not all staff had received an appraisal in the last year, with particular low compliance in the ancillary staff group.
- Consultant cover did not meet the 16-hours on-site standard and was reduced significantly at weekends. However, junior doctors felt well supported and both the local management team and trust executives were aware of this concern and had actions ongoing to improve the levels of cover.
- Receptionists did not receive any training or guidance to help them identify potentially seriously unwell patients and there was no formalised procedure for calling for help in the event of a patient deteriorating in the waiting room. However, while this presented a risk to patients awaiting triage, no incidents of harm had been reported.

Urgent and emergency services

Are urgent and emergency services safe?

Good



We rated safe as good because:

- There was an extremely positive safety culture, with staff taking an interest and personal responsibility with regard to patient safety.
- Staff were genuinely open, honest and transparent and actively reported incidents as an active tool for learning and improvement.
- Learning opportunities were identified and these were actively shared with staff to support improved safety. The use of simulation training to further embed learning was an excellent tool.
- Innovation was encouraged and the delivery of the SHINE patient safety assessment tool had delivered excellent results.
- A thorough cleaning programme was in place and records confirmed this was being completed.
- Although crowding was an issue and ambulance patients often had to queue in a corridor, this was being actively managed in a way that kept patients safe with additional staff being allocated and the use of a patient safety checklist.
- Patients arriving in the department were assessed and monitored effectively. Those arriving by ambulance were assessed swiftly within five minutes of arrival. The majority of self-presenting patients (those not arriving by ambulance) were assessed within 30 minutes of arrival.
- Medicines were managed safely and securely. Incidents relating to double administrations had led to new stickers being implemented to highlight pre-hospital medicines administration to staff.
- Staff understood their safeguarding responsibilities and actively reported concerns.
- Nursing staffing levels met national guidelines and additional nurses were called upon from the wards to support the department in times of crowding.

However:

- Mandatory training compliance within the nursing and medical staffing groups was below target for all topics.
- Consultant cover did not meet the 16-hours on-site standard and was reduced significantly at weekends,

although junior doctors felt well-supported. However, there had been no reported harm to patients and there was senior management and executive visibility of this with actions ongoing to improve the levels of cover.

Incidents

- There was a positive reporting and safety culture. All staff we spoke with were aware of their responsibility to report incidents and valued this as an opportunity to learn and improve. This was evidenced in the types and numbers of incidents reported. The department was the highest reporting area in the trust, with a large number of near misses and minor incidents being report.
- In the 2015/16 safety culture survey the department scored extremely well, with a number of responses performing higher than the trust overall.
- Incidents were reported on an electronic system, which staff told us was simple to use. All staff had access to this system.
- We reviewed a large number of reported incidents and saw evidence these were investigated and fed back to staff. Learning points were identified and shared throughout the department, and the wider hospital where required.
- There had been no never events reported in the emergency department between October 2015 and November 2016. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There had been three serious incidents in the emergency department between August 2015 and September 2016. We reviewed the investigations for all three incidents and found thorough investigations had been completed, involving both internal and external multidisciplinary teams where necessary. The investigations clearly identified where learning was possible and the action plans reflected the actions needed to address these opportunities. Actions included teaching sessions for staff and simulation training.
- There were a number of systems to ensure learning from incidents was shared throughout the department. Daily safety briefings provided immediate opportunities to share safety learning with staff. Minutes of governance and staff meetings demonstrated learning from

Urgent and emergency services

incidents had been discussed, and these minutes were circulated to staff who were not in attendance.

Simulation training was used as another tool to share learning and embed practice following more complex or serious incidents.

- Mortality and morbidity meetings were held quarterly to ensure there were sufficient numbers of cases to discuss. The meetings were consultant-led and usually just involved staff from the department, but where other specialties had input with the patient's care these reviews were jointly held. The meetings were open to all staff working in the department, but as is usual in emergency departments the core attendees were middle-grade doctors and consultants. The meetings were well documented and minutes were circulated to staff.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- All staff we spoke with had a good understanding of the duty of candour and some were able to give examples of when they had fulfilled the requirements of the Regulation.
- We reviewed several examples where patients had suffered moderate or serious harm and found evidence that duty of candour had been followed. We saw support had been given to patients and their families, explanations and apologies were provided and recorded, and investigation findings were shared once completed.

Safety thermometer

- The safety thermometer is used nationally to record patient harm and to provide immediate information and analysis for teams to monitor their delivery of harm-free care. Data collection takes place on one day each month. It is therefore only a snapshot of a single-day's performance.
- There were no reported pressure ulcers, falls with harm or catheter-acquired urinary tract infections between September 2015 and November 2016.

Cleanliness, infection control and hygiene

- Cleanliness, infection control and hygiene were very good throughout the emergency department.
- The department had clear and detailed cleaning work schedules with tasks broken down into time slots. The work schedules were comprehensive and included the cleaning of all surfaces, floors, bed spaces, bed rails, toilets and bins. Check sheets were signed once cleaning had been finished, and we saw these were complete and up-to-date.
- The department was visibly clean and the patients we spoke with told us they thought the department was very clean.
- We observed cleaning to be thorough, with staff moving objects so they could clean behind and underneath them. Hard-to-reach areas were not overlooked, and staff had the equipment to reach difficult areas, for example curtain rails and high ledges.
- All staff took responsibility for ensuring the cleanliness of the department, regardless of their role or grade. We saw nursing staff, doctors and consultants cleaning equipment they had used.
- There was good access to alcohol hand gel throughout the department.
- There had been no cases of methicillin-resistant or methicillin-susceptible *Staphylococcus aureus* (MRSA and MSSA), or *Clostridium difficile* (C. diff) in the last six months.
- We observed one patient with a potentially contagious infection being provided with a mask to prevent the airborne spread. The patient required admitting to the hospital and isolation facilities were being arranged.
- All staff were bare below the elbows and regularly used alcohol hand gel to reduce the risk of cross-infection. However, staff rarely used soap and water to clean their hands before or after patient contacts. Internal hand hygiene audits for September and October 2016 showed only 66% compliance. Data was not provided for the preceding months. Increased awareness of hand hygiene procedures was highlighted on an infection control noticeboard.

Environment and equipment

- Equipment was serviced and checked in accordance with manufacturers' and local requirements. All the equipment we checked in the department had stickers confirming the last and next inspection or service date

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and these were all up-to-date. Portable appliance testing stickers also showed all the equipment had been tested in the last year. We also received a spreadsheet of all the equipment in the department, along with the next service schedule date. All items of equipment in the department were up-to-date.

- Staff had easy access to equipment and we found storage and labelling made it easy for staff to identify and obtain the equipment they needed.
- We found the sluices were clean, tidy and well-organised. Items marked as being clean were checked and found to be visibly clean. There were clearly identifiable domestic and clinical waste disposal facilities, and we found these were being used appropriately.
- The department had a dedicated mental health assessment room, which met the required standards. There was good access and egress, furniture was appropriate and an alarm system was installed.
- Although the majors area did not have an emergency resuscitation trolley, we were assured equipment was readily available in the resuscitation area which had access directly from majors. Managers and staff described the actions they would take in the event of a cardiac arrest in majors, with the patient being taken straight into the resuscitation area. In the event the resuscitation area was full, a patient could generally be moved out of resuscitation to make space. Alternatively, a cardiac arrest patient could be temporarily accommodated centrally in the resuscitation area. As a final option, a spare defibrillator normally used to accompany critically unwell patients from resuscitation to other areas of the hospital could be easily moved into a majors' cubicle. There had been formal risk assessment of this position.
- The hospital had a helipad on the roof so air ambulances were able to land. There was good access from the helipad to the emergency department.
- X-ray and computed tomography (CT) was located adjacent to the department. This meant patients could be transported quickly to these areas.
- Ambulances had direct access to the emergency department from a covered drop-off area. Doors directly into the resuscitation area were located opposite the ambulance entrance, which reduced delay when critically unwell patients arrived.

- Patients in the waiting room could be seen from the reception desk. However, a number of the seating positions faced away from the desk so staff might not have been able to see a patient deteriorating.
- Resuscitation equipment checks were not always being recorded. While we found the emergency resuscitation trolley in the observation unit had daily checks recorded for the past three months, checks in the resuscitation area were inconsistently recorded. Although we observed checks were being carried out, staff did not always record these. In the five weeks leading up to our inspection checks had not been recorded on 13 days, although staff told us the equipment was checked daily.
- In the observation unit there were two bed spaces without fixed monitoring equipment. Although two portable machines were available, these were frequently in use in the corridor due to crowding in the department. While observations were still possible using equipment in the other bed spaces, it did mean on occasions these were delayed. This was recognised as a risk in the department with the lack of monitoring equipment being placed on the department risk register in April 2016. A capital bid for more equipment was planned for 2017.
- Chemicals were not always stored securely. On the first day of our inspection we found chlorine tablets on top of a cupboard in an unlocked sluice. We also found a bottle of toilet bleach in an unlocked cupboard in the relatives' room. We raised this with senior staff and found these had been removed on the second day of our inspection.
- The department was frequently crowded, with patients being held in a corridor until space became available in majors. We found this to be a regular occurrence during our inspection and were told by staff patients queued almost every day.

Medicines

- Medicines were managed in a way that kept people safe. Medicines were stored in locked cupboards in a locked room, accessible only with a swipe card. Keys to the medicine cupboards were stored in a separate locked safe so they could be accessed when needed. Intravenous fluids were also stored within this locked room.

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- Controlled drugs were stored securely and only authorised staff were able to access them. The controlled drugs registers were up-to-date and regular checks were recorded in all but one case.
- Allergies were recorded clearly on patient records and prescription charts in all but two of the 18 records we reviewed.
- Refrigerator temperatures were all within range and we saw daily checks were being recorded.
- Stickers were being introduced to improve patient safety. Following a number of incidents where medicines had been administered twice, usually following patient admission by ambulance, new stickers had been introduced to reduce errors. These stickers were placed on the front of patients' records to alert staff that medicines had been given by the ambulance crew prior to the patient arriving at hospital.
- There were clear disposal and destruction processes in place for wasted or out-of-date medicines. Facilities for the disposal of wasted medicines were available in the department, while destruction could be arranged through the pharmacy.
- We found a number of patient group directives in the minors area had been printed but were out-of-date. All the up-to-date directives were available on the trust intranet system. We highlighted this to staff and found the following day the printed directives had been removed.

Records

- Patient care records were well completed. We reviewed a total of 18 records and found in all but two records the notes were legible, complete, signed, timed and dated. We found all records had risk assessments and management plans completed and these were easily identifiable. While records were not stored securely in majors, the filing system used was located by the nurse in charge's station and this area was away from the patient areas and always observed. In the observation unit care records were stored securely in the enclosed nurses' station.
- The department used paper care records, which were scanned into an electronic system at a later date.
- Do not attempt resuscitation orders, when completed or handed over on the patient's arrival, were stored at the front of care records so they could be quickly located and referred to in the event of a cardiac arrest.
- Internal records audits showed variable compliance between November 2015 and October 2016. For example, in November 2015 no ECGs had been labelled correctly, while in four other months all had been labelled correctly. The year-to-date compliance was 89.7%, which was an improved position from 79.2% the previous year. Another indicator was the name and designation of the staff member completing the notes being written in full. In January 2016 no records audited had this completed, although in five other months all the records audited had this detail. The year-to-date position was 72% of records contained this detail.

Safeguarding

- Most clinical staff working in the emergency department were up-to-date with level two adult safeguarding training. Within the nursing staff group, 96% of those staff required to complete this training had done so. Within the medical staff group, 74% of those staff required to complete this training had done so. The trust target was 90%.
- Not all clinical staff in the emergency department had completed children's safeguarding training. Against a target of 90%, only 56% of nursing staff and only 43% of medical staff had completed level three children's safeguarding training. Although the children's emergency department was completely separate, staff in the adult emergency department still came into contact with children who had come in with an adult and therefore should have received some form of children's safeguarding training.
- Staff were aware of their safeguarding responsibilities and knew the processes to follow in the event of a safeguarding concern being identified. All the staff we spoke with were able to talk through the process of reporting a safeguarding concern, and could show us where to find help and guidance to support them. They were able to tell us about the different types of abuse and knew how to manage incidents or concerns or about female genital mutilation.
- We saw a laminated flowchart in majors outlining the safeguarding process, and a dedicated area on the trust's intranet provided additional information and contact details for the safeguarding leads.
- Concern forms had been introduced and were well used by staff where concerns were identified that may not fit strictly into safeguarding criteria but required a multi-agency review. These were sent to the trust's

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safeguarding team and regular review meetings took place with other agencies, including the local authority, where further actions to address any concerns were agreed.

Mandatory training

- Mandatory training compliance did not meet the trust target. The trust had a target of 90% compliance for all mandatory training, but within the medical and nursing staff groups in the emergency department no topic met this target. Compliance ranged from 37% (information governance) to 78% (conflict resolution awareness, conflict resolution training, and equality and diversity).
- Mandatory training was monitored centrally by the trust's training centre and monthly updates were received by the department's clinical nurse educator. The clinical nurse educator then identified those who needed to complete any statutory and mandatory training and updated a list in the staff room.
- Staff told us they found accessing mandatory training difficult because they were often too busy on a shift to be released. Since the one-day training had been stopped in preference of separate e-learning modules, staff told us they had found it more difficult to be released to complete it. Staff were able to complete the training in their own time, but this was discouraged by the department and the trust because it was a work-based activity and staff needed time to rest away from work.
- Training in the identification and management of sepsis was included in the induction of all new staff. This included familiarising staff with the trust's policies and processes.

Assessing and responding to patient risk

- Patients in the emergency department were kept safe through the use of observation tools. Having recognised the impact of crowding in the department on patient safety, and particularly the increased risk for patients waiting in the corridor, a research project was undertaken which resulted in the introduction of a new patient safety checklist. The SHINE project was introduced by the department in November 2014 and provided staff with a simple checklist to ensure patient-safety based actions were completed. Since its introduction there had been no incidents of a deteriorating patient not being identified and then managed.

- In every record we looked at in majors, minors, resuscitation and the observation unit we found the patients had all had observations completed and documented on an hourly basis. An early warning score system was being used, and since the introduction of SHINE the recording of an early warning score had increased from 51% to 82%.
- Patients arriving by ambulance were assessed promptly. The department performed better than the England average in the 12-month period between October 2015 and September 2016. During this period the average time from arrival to initial assessment was five minutes. The national average was six minutes. During our inspection we found even when the department was crowded and patients were queuing in the corridor, initial assessments were completed without delay to ensure patients were safe.
- Risk assessments were used routinely throughout the department and included mental health, pressure areas, venous thromboembolism (VTE) and sepsis. We saw these used in care records to assess patient risks and create management plans to reduce those risks.
- Patients requiring diagnostics, or who were awaiting results of diagnostic tests, out of the department were escorted when necessary. The department had written criteria identifying the patients who required an escort. These included patients who were immobilised or had increased early warning scores. We observed all the patients fitting the criteria during our inspection were accompanied.
- Patients with suspected sepsis were identified and treated early through the use of a sepsis screening tool and treatment pathway. Patients with suspected sepsis were identified on the majors whiteboard with a 'sepsis' magnet so all staff were aware and able to take proactive action to manage them. We observed three patients who had presented with symptoms suggesting they may have sepsis and found in each case the screening tool and treatment pathway had been completed.
- A dedicated mental health assessment matrix was being used to risk assess patients presenting with mental health conditions. Depending on the risk, actions to take were highlighted to staff so patients could be managed safely.
- Patients who arrived at the department having made their own way presented to a reception desk in a main waiting room. Receptionists took patients' basic details,

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including what was wrong, and entered these on a computer system. A triage nurse was then able to see the details and would call patients through in order of their arrival. However, if the triage nurse saw any potential 'red flags', for example chest pain, they could reprioritise the waiting queue. Receptionists were not trained to recognise serious concerns or 'red flags' and were not provided with any guidance to help them recognise patients who were potentially seriously unwell or at risk of deterioration. However, all the receptionists we spoke with said they used their common sense and would call for help if they were concerned about a patient. Receptionists did not have a formal process for summoning help in the event of a patient deteriorating in the waiting room. They told us they would shout to the triage nurse in the next room, or through to minors if the triage nurse was not there. However, while this presented a risk to patients awaiting triage, no incidents of harm had been reported.

- Patients who arrived at the department having made their own way were not always assessed promptly. Between November 2015 and October 2016 the average time from arrival to assessment was 27 minutes. The longest average wait time was 33 minutes in October 2016. Only 38% of patients who were not brought to the department by ambulance were assessed within 15 minutes, and only 66% of patients were assessed within 30 minutes and 91% within 60 minutes. This area of performance had been identified in a departmental team meeting but actions to understand and address the issues had not been identified. However, there was no evidence of patient harm as a result of delayed triage.
- On the first day of our inspection we observed ten patients in minors waiting for triage. Between 2.20pm and 4pm all ten patients we observed had to wait longer than the 15 minute standard for time to initial assessment. The average triage time for these patients was 26 minutes. On the second day of our inspection we reviewed eight records and found one did not have a triage time recorded and of the other seven only two had been triaged within 15 minutes.
- We found patient call bells were not being made accessible to all patients in majors. Although staff had good visibility into most cubicles, they were not being observed at all times. We highlighted this concern on

our first day and found action had been taken to resolve the issue on our second day. We also found all patients had access to a call bell on our unannounced inspection.

Nursing staffing

- The emergency department used a scoring system for acuity and dependency. The tool was used daily to review staffing levels based on the needs of the patients in the department. Advanced staffing levels were planned using historical data, including attendance numbers, acuity and dependency.
- Staffing levels met national guidance and kept patients safe, although staffing in minors was highlighted by staff as a concern because of timeliness of assessments and the impact on patient experience. On every shift it was planned there would be one band seven or band six senior shift coordinator, two band five registered nurses in the observation unit looking after up to eight patients, two band five registered nurses in minors, three band five registered nurses in majors looking after up to 11 patients and either two or three band five registered nurses in resuscitation looking after up to six patients. During the day at least one unregistered nursing assistant provided additional cover, while at night there were at least two. Emergency nurse practitioners also worked in the department covering the full 24-hour period.
- During times of crowding, additional nursing cover could be requested from the wider hospital to release emergency department staff to look after patients in the corridor. We saw this system working well and patients told us they felt safe. However, some nursing staff from the wider hospital told us they were sometimes allocated to the corridor, which they felt uncomfortable with because they were not from an emergency department background.
- At the time of our inspection there were 2.7 whole time equivalent registered nurse vacancies at band seven, with interviews planned in December 2016. There were also two band six registered nurse vacancies. Band five registered nurses had been over-recruited to help manage the impact of staff turnover within this staffing group. There were an additional five whole time equivalent band five registered nurses. We did not see this have any adverse impact during the inspection, and staff told us the skill mix and staff numbers were ok.

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- Data provided by the trust showed between May and August 2016 all shifts were fully staffed, with some months having increased staffing numbers.
- Between September 2015 and August 2016 the bank and agency usage rate was 11.7% in the emergency department. The department was working hard to reduce its agency spend and used bank staff in preference of agency staff as often as possible. These bank staff were trust employees and were familiar with the department so it was believed to be safer, as well as more economical.
- A structured handover process between shifts ensured patients were kept safe. The oncoming nurse in charge received a handover from the off-going nurse in charge. Every patient in majors and the observation unit were discussed in turn, covering what the patient presented with and the plan for their assessment and/or treatment. When the matron was on duty they also attended the handover but were able to leave and accept ambulance patients so the nurses in charge could continue the handover. Once the patients had been discussed, the 'ABC of handover in the ED' was followed which covered various areas of the department, including bed availability and breaches, colleagues (sickness, issues), deaths, disasters, deserters, drug charts, discharge summaries, equipment issues, friends and family test completion and gaining knowledge (any teaching or training needed).
- The nursing staff meanwhile took individual handovers for the patients they would be looking after. These handovers were also well structured and included discussion about social considerations, medicines, pressure areas, observations, the patient's presenting complaint and any blood results. Once the handovers had been completed the nurse in charge then delivered a safety briefing to each nurse in turn.
- All new staff had a comprehensive induction process. This included a three-day induction followed by a two-week supernumerary period. The programme included assessing patients, meeting all the specialist nurses, handovers, orientation and equipment familiarisation. One new starter who had been through this process told us they felt much safer knowing the induction process had been so comprehensive. Staff supporting the department from other areas of the hospital received basic familiarisation and guidance from the nurse in charge.

Medical staffing

- Medical cover generally kept patients safe, but consultant cover was recorded as a risk in the department, particularly at weekends.
- Medical cover Monday to Thursday was provided by two consultants during the day and two consultants in the evening, one of whom was on-call overnight. On Fridays this reduced to one consultant on the evening shift and at weekends there was just one consultant covering the department. Middle-grade and junior doctors worked a variety of shifts covering the whole 24-hour period and a minimum of an ST4 was on duty in the department at all times.
- Consultants were not planned to provide a minimum of 16-hours on site cover. During the week consultant cover was provided 8am to 10.30pm, although we were told they usually worked until midnight. After 10.30pm a consultant was on-call. At weekends consultant cover was only provided 8am to 5pm, with the remaining hours being covered on an on-call basis.
- Overnight on Monday to Thursday there were two middle-grade doctors on duty providing medical cover for the department, and on Fridays, Saturdays and Sundays this was increased to three. Junior doctor cover mirrored the middle-grade cover overnight.
- The department had completed a benchmarking exercise and identified they had fewer consultants when compared with other departments locally. It was recognised they were unable to meet 16-hours of planned consultant presence, and the weekend was highlighted as a particular risk. We were told a business case was being put together to request additional funding so medical cover could be strengthened.
- Military doctors worked in the department on a supernumerary basis and we were told this worked well. However, it was felt by department managers if these military doctors were not available the department would struggle to provide adequate medical cover.
- Between September 2015 and August 2016 the bank and locum usage rate was 3.3% in the emergency department.
- We observed a medical handover and found it to be comprehensive. We observed excellent communication between the whole medical team at the handover, with each doctor taking the time to handover their patient in detail with others clearly listening. Patient safety considerations were highlighted and the opportunity to

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have a quick learning discussion was maximised. In the same way as the nursing handover, the medical team finally completed the 'ABC of handover in the ED'. The handover was also attended by the nurse in charge, psychiatric liaison and representatives from a partner organisation providing the REACT service.

Major incident awareness and training

- The trust had major incident and business continuity plans in place. These were readily accessible and included action cards relevant to the emergency department. Most staff we spoke with were aware of the major incident arrangements and knew how to access the action cards and major incident equipment.
- An emergency decontamination tent was stored outside the department and could be erected in the event of an incident requiring patients to be decontaminated.
- Security were based in the department out-of-hours. In-hours, we were told security staff were very responsive if needed. Reception staff told us they received verbal abuse on a daily basis and reported this in most instances. They told us they were well-supported by security and emergency department staff and managers in these circumstances.

Are urgent and emergency services effective?

(for example, treatment is effective)

Outstanding



We rated effective as outstanding because:

- The safe use of innovative approaches to care and how care was delivered was actively encouraged. This included simple solutions, such as a touchscreen guideline system in the resuscitation area, and the close working relationships with external partners to deliver alternative care pathways and admission avoidance programmes. The SHINE patient safety assessment tool had driven significant improvements and clearly demonstrated improved outcomes.
- All staff were actively engaged in activities to monitor and improve quality and outcomes, including

benchmarking and peer review. A thorough multidisciplinary audit programme was in place and actively used by staff to encourage and monitor improved outcomes.

- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. There was a clear focus on staff learning and development, with staff being supported and sponsored by the department and the trust to complete additional relevant qualifications.
- Staff delivered strong multidisciplinary working both within the department, and with staff from other departments or organisations.
- There was a truly holistic approach to planning people's discharge or transfer to other services, and this was done at the earliest stage. Staff from two external agencies worked proactively within the department to support discharges with increased social care provision, and to provide a 'virtual ward' to allow patients to be cared for at home. Staff in the department worked closely with these teams and engaged with them promptly after a patient had been assessed.
- Staff demonstrated a clear understanding of consent and best interest decision practices and records evidenced these were being followed. Consent practices ensured people were involved in making decisions about their care and treatment.

However:

- Not all staff had received an appraisal in the last year, with particular low compliance in the ancillary staff group.

Evidence-based care and treatment

- The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided. Guidance was regularly discussed at team meetings, and regular audits were completed and learning opportunities shared with staff.
- A range of clinical care pathways and proformas had been developed in accordance with national guidelines. These included treatment of stroke, sepsis, asthma, fractured neck of femur (broken hips), acute coronary syndrome, diabetic ketoacidosis, upper gastrointestinal

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bleed, suspected pulmonary embolism and mental health problems. We found these were understood by staff and were being used effectively to manage patients' care.

- Following the introduction of the SHINE patient safety assessment tool compliance with the evidence-based sepsis pathway had increased from 93% to 95%. An increase in compliance with the evidence-based stroke pathway was also seen, rising from 86% to 97%. For patients with a fractured neck of femur, evidence-based pathway completion increased from 92% to 97%.
- A programme of multidisciplinary audits was used to check care and treatment was being provided in accordance with national guidelines. Where performance could be improved action plans were completed and learning was shared with staff. Further audits were then completed to check performance had improved. For example, in February and March 2016 an audit was completed against the NICE guideline CG176 for head injuries. The audit identified poor performance in documentation of a cervical spine assessment, computed tomography (CT) reporting times and the provision of written head injury advice. A poster was devised that reminded staff of the guidelines, showed the audit findings and the actions being taken to improve performance. A further audit was completed in June 2016 and showed an increase in performance. We saw similar audit posters covering the recording of referral discussions and management advice for patients with an intracerebral haemorrhage, reviewing blood culture sampling, and cervical spine imaging.

Pain relief

- Patients had their pain assessed and managed promptly. In all the records we reviewed all patients had an early pain score recorded and timely administration of pain relief where required.
- All patients we spoke with were comfortable and told us they had been asked if they were in any pain and offered pain relief.

Nutrition and hydration

- Following assessment of a patient, intravenous fluids were prescribed and administered when clinically indicated.
- We observed nurses, healthcare assistants and members of the catering team providing water, hot

drinks and snacks for patients. Before offering any food to patients, staff checked with the nurse and doctor, where appropriate, to check the patient was able to eat and drink.

- Patients we spoke with told us they had been offered drinks and snacks where appropriate.

Patient outcomes

- The department had taken part in a number of national audits since 2014, including the Royal College of Emergency Medicine 2014/15 audit for assessing cognitive impairment in older people, and mental health in the emergency department 2014/15 audit.
- In the cognitive impairment audit the department scored in the upper quartile compared to other hospitals for two measures, in line with the England average for three measures and in the lower quartile for one measure (having an early warning score documented). Since the introduction of the SHINE patient safety checklist early warning scores were routinely documented for all patients, and this was evident during our inspection.
- In the mental health audit, the department scored in the upper quartile for two measures, compared equally with the England average for four measures, and was in the lower quartile for two measures (provisional diagnosis documented and assessed by a mental health practitioner within one hour). Although the trust had increased psychiatric liaison provision, this standard remained poor. However, mental health services were provided by an external provider and the trust was working closely with them and commissioners to try and improve the service response time.
- Other national audits had taken place since 2013, including the Royal College of Emergency Medicine 2013 consultant sign-off audit, paracetamol overdose 2013/14 audit and severe sepsis and septic shock audit 2013/14. In the absence of formal Royal College of Emergency Medicine re-audits, the department had proactively re-audited their performance following action plans being completed and these demonstrated outcomes were being improved.
- Following all audits, clear action plans were put in place to increase performance where needed, and re-audits had either taken place or were planned. Where re-audits had taken place there was a demonstrable improvement in performance. For example, the correct

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assessment of risk, appropriate blood tests being sent and use of a departmental flowchart to assess the need for blood thinners in venous thromboembolism in lower limb immobilisation.

- Additional local audits included asthma management and seizures. Again, where standards were not being met there were clear recommendations and action plans produced to improve performance in those areas, including re-audits in the future and these were showing improvements were being made.
- Audit meetings were held to discuss the progress of audits and present audit results and recommendations once completed. These meetings were recorded and minutes were circulated to staff.
- The department was about to start a project with pre-hospital partners, including the ambulance service and GPs, to help further improve patient outcomes. The pre-hospital partners had agreed to trial an early warning score system so differences pre-hospital, on arrival and during assessment, observation and treatment could be compared and considered.
- Following the introduction of the SHINE patient safety checklist, improvements in pathway compliance had been seen in a number of areas. This in turn promoted improved patient outcomes.
- Unplanned re-attendance rates between October 2015 and September 2016 were about 8%. This was higher (worse) than the national standard of 5%, but similar to the England average of 7.5%.

Competent staff

- New starters in the department received a structured induction and orientation programme, overseen by a clinical nurse educator and practice development nurse. For nursing staff there were two routes, depending on whether or not they had previous emergency department or critical care experience. Both routes included a period of two weeks supernumerary practice, including either one-to-one resuscitation experience and the first of a two-part induction, or both parts of the induction. Further development goals included 1:1 shifts with the practice development nurse, resuscitation training and triage training.
- Other external and internal courses were also available, including point of care simulation, human factors

training, male catheterisation, trauma immediate life support, advanced life support, advanced trauma life support observer, minor injury and illness, and plastering.

- Staff were supported by their managers and the trust to attend additional courses. Study leave could be approved for 75% of the study time needed, with staff completing the other 25% in their own time. The department had six staff on the principles of emergency care course at a local university, and planned to allow more to complete this when further opportunities arose. A further two members of staff, both assistant practitioners, were also being sponsored by the trust to complete their training to become registered nurses. This required two years study at university.
- Student nurses received a one-day induction and were allocated mentors who they worked with in a supervised, supernumerary capacity.
- The department employed a clinical nurse educator for 15 hours-a-week. Although they would have liked more hours to deliver more education, the benefit of just 15-hours was being noticed by staff who felt well-supported with their ongoing development. Additionally, a practice development nurse worked one shift a week, with a focus on training and support on the 'shop floor'.
- There was protected teaching time for the emergency nurse practitioners every Tuesday for one hour. The sessions frequently had guest speakers from other specialties and the time was also used to discuss complex or particularly interesting cases.
- Middle-grade doctors had four hours protected teaching time every Wednesday afternoon. The sessions covered safety updates, including learning from incidents. The staff we spoke with valued this highly.
- Medical staff also had the opportunity to attend annual practical procedures training and this was run jointly with another local hospital. Doctors told us they felt well supported by a positive culture of education and teaching.
- A comprehensive register of the equipment used in the department was held by the clinical nurse educator. We reviewed the log and saw staff were signed off as being competent on each piece of equipment before they were permitted to use it unsupervised.
- Not all staff in the emergency department had received an appraisal in the last year. In the year 2015/16 only 78% of staff had received an appraisal, against a trust

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target of 85%. Administrative and clerical staff had the highest compliance at 94%, while 81% of nursing staff, 75% of medical staff and only 29% of ancillary staff had received an appraisal. We were told by department managers the biggest difficulty with completing appraisals was releasing staff from the department to attend. Managers told us they were working hard to release staff for their appraisals, prioritising quieter times in the department, but due to demand were still finding this difficult.

Multidisciplinary working

- Effective multidisciplinary working was evident in the emergency department. We observed all staff across all grades, functions and departments working exceptionally well together. Communication, support and challenge were encouraged by excellent relationships between everyone. In one example we observed a nurse constructively challenging a doctor about the prescription of medicines for a patient. The two members of staff discussed the options together and reached agreement about the diagnosis and treatment plan before the medicines were prescribed and administered.
- All the ambulance staff we spoke with told us they had really good working relationships with the emergency department staff. They told us they were listened to at handover and felt valued and respected as part of the emergency team by all the emergency department staff.
- The department was working closely with two external organisations who were based within the hospital. The trust had contracted with a third party organisation to provide a 'virtual ward' by providing medical and nursing care in a patient's home wherever possible, and REACT reviewed social care packages and arrangements to help facilitate discharges of patients to their home rather than having to be admitted to a hospital bed. We saw excellent working relationships between the external and internal staff, with a clear focus on working together to achieve the best outcome for the patient.
- While timely access to the external mental health provision was difficult, we observed good relationships when staff did arrive in the department. Additionally, increased numbers of psychiatric liaison nurses had improved communication and support for the department.

Seven-day services

- Imaging services were available 24-hours-a-day, seven-days-a-week. These were located next to the department and staff told us they were able access the service in a timely way. Once completed, emergency department staff were able to view the images on the department's computers, prior to a formal report being received. We were told there was sometimes a short delay in the report arriving, but staff felt this was minimal. Out-of-hours reporting was completed remotely by telemedicine. Staff told us this service worked well and provided timely reporting and discussion.
- Consultants provided cover 24-hours-a-day, seven days-a-week. This was either on site or on-call. Junior and middle-grade doctors told us the consultants were always accessible and gave them good support. They said consultants were always willing to come in if they were on-call, even if this was not specifically requested.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and guidelines were either included in proformas or easily accessible from the trust's intranet site.
- In the resuscitation area four bays had been fitted with touchscreen monitors allowed staff to immediately access emergency guidelines, protocols and medicines. This had been developed internally by one of the consultants and was well-utilised by staff in emergency situations.
- The trust used a computer system to enter patient details and allow internal tracking. In the emergency department this computer system displayed the various performance times for patients in the department, allowing easy identification of patients who had been in the department a long time and needed actions to be taken. This system could also be viewed by the clinical site and bed management team and helped with planning beds.
- Additionally, the computer system displayed warning flags to highlight to staff patients who may need extra support, for example patients with learning disabilities or who may require language translation services. These flags also alerted specialist teams in the hospital who would make contact with the department to provide any additional support needed.

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- Notes for patients who were admitted or transferred travelled with the patient and were handed over to staff at the destination to ensure continuity of care and access to the history of their time on the emergency department.
- Discharge letters were sent to GPs daily and included relevant and pertinent information for their attention.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had an excellent understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and consent. All staff we spoke with were able to clearly communicate their responsibilities. In all the records we reviewed we observed consent had been obtained and recorded where appropriate, and where consent was refused this was clearly documented, along with confirmation the patient had the capacity to make that decision.
- The trust's intranet site had a section dedicated to the Mental Capacity Act and provided staff with easy access to policies and guidance. Best interest discussion paperwork could be printed directly from the intranet site and provided a clear template for staff to record best interest discussions and decisions.
- For patients who required emergency decisions to be made for them, for example patients who were unconscious, staff made decisions in the patient's best interest and clearly documented these in the patient's records.

Are urgent and emergency services caring?

Good



We rated caring as good because:

- People were treated with dignity and respect and staff were mindful of confidentiality and privacy.
- Care was delivered compassionately by all staff and at all times.
- Staff took time to ensure patients and their relatives understood their care, diagnosis and treatment plans.
- Patients and their relatives received emotional support.

However:

- Patient privacy and confidentiality could not be maintained in the corridor when the department was crowded.
- Between September 2015 and August 2016 the department scored lower (worse) than the England average in the NHS Friends and Family Test.

Compassionate care

- People we spoke with praised the staff for their kindness and compassion. Patients told us they had been treated with dignity and respect at all times.
- Staff took the time to ensure patients were comfortable, responding compassionately to patients in pain or distress and giving reassurance and support.
- We observed doctors and nurses introducing themselves when they met patients and their families for the first time. All patients were addressed by their preferred name.
- The department had received lots of positive feedback about the compassionate care provided in the form of cards and letters, and these were displayed in the staff room.
- We saw staff from all groups assisting patients and others who were confused or lost in the department in a helpful and supportive manner. One doctor was seen helping a patient to the toilet.
- Privacy in the reception area had been considered and an auditory barrier had been built in front of the reception desk to prevent other people in the waiting room being able to hear what was being said.
- Staff used curtains around the bed spaces to provide privacy when assessing and treating patients, and ensured patients' dignity was maintained when curtains were opened.
- Patients in the corridor, however, did not have the same provision to ensure their privacy. Staff did their best to ensure confidentiality and privacy in the corridor by keeping conversations as quiet as possible, but because of the close proximity of other patients and relatives conversations could still be overheard.
- Between September 2015 and August 2016 the department scored lower (worse) than the England average in the NHS Friends and Family Test. The percentage of patients who said they would recommend the department ranged from 71% in March 2016 to 80% in August 2016. The national average across the same period ranged from 83% to 88%.

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Understanding and involvement of patients and those close to them

- Most patients and their relatives received regular communications and were kept informed about their care, treatment and condition. Staff made sure patients and relatives understood the assessments being done and the likely diagnosis and treatment plan. Patients and relatives were given opportunities to ask questions and staff gave them time to do this.
- However, one patient and their relatives told us they would have liked more communication while they were waiting for further examinations to be completed. They told us this was taking a long time and they didn't feel updated.
- We observed one doctor taking a medical history from a patient and explaining the tests they were going to carry out. The consultation was undertaken in an unhurried and sensitive manner and everything was explained to the patient in a way they could understand.
- We also observed nursing staff taking time to read through and explain patient information leaflets to ensure patients understood what they needed to do before they were discharged.

Emotional support

- Emotional support was provided to patients and relatives. On two occasions we saw families of patients being cared for in the resuscitation area being given emotional support by nursing staff. Both families were made comfortable in the relatives' room to provide some privacy and the nurses took time to talk with them and help them understand what was happening. The families were given regular updates and the nurses regularly checked on their welfare. On another occasion we saw a distressed patient being comforted by a nursing assistant.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement



We rated responsive as requires improvement because:

- The trust was consistently failing to meet the national standard which requires 95% of patients to be discharged, admitted or transferred within four hours of their arrival at the emergency department.
- The emergency department suffered from regular crowding, and this was cited as the department's greatest risk. This was on the corporate risk register.
- Wheelchair users and patients with mental health conditions were not having their needs met.
- Patients spent longer in the emergency department compared to the England average.
- The percentage of patients waiting between four and 12 hours from the decision to admit until being admitted varied, but was regularly higher (worse) than the England average.
- Patients with mental health conditions were not formally assessed and found the most suitable treatment pathway in a timely manner, although this service was provided by an external provider.

However:

- The emergency department and the trust were working closely with commissioners and partners to address system-wide flow issues and introduce innovative methods to improve patient flow.
- There was good support for patients living with dementia or learning difficulties, and translation services were available for patients whose first language was not English.
- The trust escalation policy provided good support to the emergency department at times of increased pressure.

Service planning and delivery to meet the needs of local people

- The emergency department and the trust were working closely with commissioners and other partners to identify system-wide strategies to improve patient flow. Projects were ongoing included the 'virtual ward' and REACT social care service, both of which were helping with admission avoidance.
- The department saw a high number of patients with mental health conditions, and drug or alcohol abuse. An eight-bedded observation unit allowed patients who required ongoing monitoring for up to 24 hours to be admitted without using a hospital bed. Although a large

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number of patients with mental health conditions were admitted to the observation unit, it was also able to accommodate other patients who required less than 24 hours of observation, treatment or diagnostic tests.

- There was a mental health assessment room in the observation unit that was appropriately designed and allowed a private and safe area for mental health assessments to take place.
- The waiting room was adequately sized to accommodate the numbers of patients and their relatives or friends most of the time. However, when it was busy people did have to stand.
- A project was well underway to improve signage and patient information throughout the emergency department. This project had been undertaken with the Design Council and installation was due to be completed in December 2016.
- An emergency nurse practitioner-led 'see and treat' service ran in minors between 8am and 2am. This service was designed to help reduce some of the demand by promptly identifying patients who could be seen, assessed, treated and discharged relatively quickly.
- A GP-led support unit was available at the hospital and the department was able to refer one patient an hour to help reduce demand in minors. Staff wanted to increase the number of referrals they could make to further help manage demand, telling us they believed they could refer up to four appropriate patients an hour if this was agreed. This was still under discussion at the time of our inspection.
- A relatives' room was provided in the majors' area so relatives and friends of patients had somewhere quiet to sit and make drinks. However, some of the furniture in the room was damaged and some relatives told us it wasn't very inviting.
- All the patients and relatives we spoke with either in the waiting room or in minors were concerned there was no information about current waiting times. They told us they could see patients coming back from seeing a doctor but there was then a long delay before the next patient was called through, even though the waiting room was not busy. Managers told us they hoped the Design Council project would help to address this by providing more information about the different stages in the patient journey through minors.
- The needs of patients in wheelchairs were not being met. Although access to the department's main entrance was straightforward through the use of a lift or an automatic door at the drop-off point, once at the door to the waiting room it was difficult for wheelchair users to gain access. The door was relatively heavy and was not automatic.
- Additionally, although the reception desk had a lowered section to accommodate wheelchair users, large computer monitors obstructed the view. Staff therefore had to stand and look down at wheelchair users while trying to enter details into the computer system.
- The needs of patients with mental health conditions were also not being met. The department's risk register carried a risk from April 2012 that mental health patients presenting to the department were "at risk of increased harm" due to excessive waits for assessment. We found this was still the case, although the hours of the psychiatric liaison service had been increased. The mental health assessment provision was provided by an external provider and the trust was trying to resolve longstanding issues with the responsiveness of the service, but no improvements had yet to be seen. During our inspection we observed two patients in the department for over 12 hours because they were awaiting mental health assessments. Not only did this impact on capacity in the emergency department, it also led to increased stress and anxiety for these patients.
- We spoke with the father of one patient who had been in the waiting room for over nine hours because a mental health practitioner had yet to arrive and assess the patient. They had arrived in the department at 2am and were becoming increasingly uncomfortable and tired.
- Another patient was admitted having taken an overdose. They arrived in the department at 10.30pm and were subsequently admitted to the observation unit to await assessment by a mental health practitioner. A mental health consultant reviewed the patient over 12 hours later at 11.15am and agreed the patient would need an assessment under the Mental Health Act 1983. The patient then left the department and took a further overdose before being returned to the department by the police at 2.25pm. The patient was placed under temporary detention under Section

Meeting people's individual needs

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5(2) of the Mental Health Act 1983 at 3pm to prevent them from harming themselves again. The patient was finally assessed and placed under section at 4.30pm, 18 hours after they had first been admitted.

- Multiple information leaflets were available, but these were all provided in English. Although other formats were offered, including braille, large print or email, there was no provision of leaflets in other languages.
- Leaflets available included head injury advice and how to treat your injured ankle (the two most common leaflets handed out), services to help you (including counselling, mental health and psychiatric services, housing and money problems, alcohol and drug problems, women's services, and refugee action), and what to expect from services for patients living with dementia.
- The observation unit had separate male and female toilets and showers, with disabled facilities.
- Water was available in various places throughout the department, and the relatives' room had provisions for people to make themselves cups of tea and coffee.
- Patients with dementia were highlighted on the majors' whiteboard with a forget-me-not sticker. A booklet called 'All about me' was available and patients or someone close to them were asked to complete information about them to help staff meet their individual needs. This included the patient's preferred name, any communication difficulties or preferences, how their mobility was, and what food and drink they liked and disliked.
- A learning difficulty team was available to support patients in the department if needed. An alert could be placed on the computer system by staff and this automatically flagged up to the learning disability team. A nurse from the team would then make contact with the department and could provide any support or guidance needed. If necessary, a team member would attend the department to give additional support.
- Staff were able to access interpreters for patients whose first language was not English. This could be arranged through an external company over the telephone. A computer alert was created so all staff could see interpreters were needed, and in the event of the patient coming back to the hospital this flag would be immediately available for staff to see.

Access and flow

- The emergency department was consistently failing to meet the national standard requiring 95% of patients to be discharged, admitted or transferred within four hours of arrival. Between November 2015 and October 2016 the department failed to meet the standard in any month, with performance ranging from 73% in October 2016 to 89% in November 2015. Performance against this standard showed a trend of decline between October 2015 and March 2016. Performance then improved, however remained below the standard each month up to October 2016. Nationally, emergency departments are struggling to meet this standard, with the national average performance over the same period ranging between 87% and 93%. However, with the exception of May 2016, this emergency department was also performing below (worse than) the national average.
- The percentage of patients waiting between four and 12 hours from the decision to admit until being admitted increased sharply from 11% in December 2015 to 27% in January 2016. Performance stayed high until May 2016 where it fell back to 7%. Rates then fluctuated around the England average until September 2016, before rising in October 2016 to 25%.
- Patients spent longer in the emergency department compared to the England average. Between July 2015 and June 2016 the average total time in the department for admitted patients ranged from 140 to 165 minutes. The England average over the same period was between 130 and 155 minutes. We were told this was due to the flow issues through the hospital.
- There were 275 ambulance handover delays over 60 minutes between September 2015 and August 2016. Performance was variable throughout this period and ranged from 13 delays in October 2015 to 31 delays in December 2015.
- Between August 2015 and July 2016, 16 patients waited more than 12 hours from the decision to admit until being admitted.
- We were told by managers and staff that crowding was the biggest risk to the department, although patient safety was being well-mitigated. Crowding in the department was on the corporate risk register.
- Staff and managers told us increasing demand was causing issues with higher numbers of attendances, and at times this was being exacerbated by the medical and surgical take. When patients who were being admitted to medical or surgical wards in a planned,

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non-emergency capacity did not have a bed to go to, they were managed in the emergency department until a bed became available. We reviewed the numbers of medical and surgical expected patients coming through the department and found 736 medical patients and 633 surgical patients had been through the emergency department between April and October 2016. The numbers of medical patients had increased by 207 on the same period in the previous year, but the numbers of surgical patients had decreased by 327. This showed the overall numbers coming through the department remained similar compared to last year.

- Managers and staff also highlighted difficulties with discharging patients from hospital back into the community and the impact this was having on patient flow through the hospital. This then had a cumulative impact in the department and contributed further to crowding.
- The department was trying a number of approaches to help manage the situation, and was being supported by the trust to do so. For example, patient flow coordinators worked in majors 24 hours-a-day, seven days-a-week to help with oversight of flow through the department. The team had been nominated for an internal recognising success award and had been recognised as “an important part of the administrative cog that keeps this busy department moving.”
- Another approach was the collaboration with a third party provider to provide a ‘virtual ward’. This started in July 2016. At the time of our inspection the service had capacity for 25 patients (with 16 patients using the service), although this capacity was planned to increase to 35 in December and to 50 in 2017. The third party provider team worked closely with the emergency department to identify and assess patients who could be transferred to the service for ongoing care in the community rather than on a ward. This promoted faster discharge from the department, and also kept hospital beds free.
- Another partner was providing a service called REACT. Again, the service’s staff worked closely with the emergency department to identify and engage with patients who could be discharged home but required additional social care provision to facilitate this.
- A pilot was also due to start in December 2016 to help manage the medically expected patients in a better way. This would see nurses from the emergency department staff the ambulatory care unit, so medically expected

patients who do not require a bed could be observed and monitored while a bed is found for them. Staff in the emergency department told us they would not want to staff this permanently because they were not emergency patients, but recognised the need to complete a trial and support a hospital-wide approach to managing patient flow.

- Patients usually received treatment within one hour of arrival at the emergency department. The Royal College of Emergency Medicine recommends the time patients should wait between arrival and treatment is no more than one hour. In the 12 months between October 2015 and September 2016 this standard was met in nine months. Performance against this standard showed a stable trend, generally better than the standard.
- The department performed better than the England average for the percentage of patients who left the department before they were seen. Between July 2015 and June 2016 the emergency department performed consistently in this area, with between 2% and 2.7% of patients leaving before they were seen. The England average was between 2.7% and 3.6% over the same period.
- Operational grip meetings took place in the department twice a day and were attended by the clinical site managers from medicine and surgery, plus the lead for the day, the emergency department nurse in charge, ambulatory care senior nurse, medical admissions unit senior nurse, and the matron from the older person’s unit. At the meeting the trust’s escalation status was confirmed, and bed pressures, expected transfers and admissions, and staffing were all discussed. Additionally, cover staff for the corridor were planned in advance so help could be called quickly when needed.
- The trust had a well-written escalation policy with good support mechanisms from across the trust. Staff told us they thought the escalation processes worked, but believed there were issues with being on red (high escalation) or black (critical escalation) for long periods because this not sustainable and the efficiency of the system decreased over longer periods.

Learning from complaints and concerns

- Complaints were handled in accordance with trust policy. If a patient or relative wanted to make a complaint staff initially tried to resolve the concerns locally. However, if this was not possible and they wanted to make a formal complaint they were directed

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to the patient support and complaints team.

Information about the patient support and complaints team was available in leaflet form and was displayed in the waiting room.

- Between February and August 2016 there were 57 complaints about the emergency department. This equated to 11% of all complaints received relating to the Bristol Royal Infirmary. It took an average of 35.2 days for the trust to investigate and close these complaints. The trust had a standard timescale of 30 days for complaint resolution, however, where necessary longer timescales were agreed with the complainant depending on the complexity of the issues.
- Formal complaints were investigated by senior staff in the emergency department. Staff involved were included in the investigation process and given support where necessary.
- Learning from complaints was discussed at governance meetings, team meetings and, if safety related, during safety briefings.

Are urgent and emergency services well-led?

Outstanding



We rated well-led as outstanding because:

- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There was a continued focus and drive from the leadership team to improve safety and quality.
- Staff satisfaction across all groups was high and staff were proud to work in the department.
- Staff spoke of a highly supportive and open safety culture. They were encouraged to raise concerns to identify learning opportunities and felt safe in doing so.
- There was strong collaboration and support across all functions and staff groups, with a common focus on improving the quality of care and people's experiences. A strong audit programme had a safety and performance focus, and all staff were involved with the programme. Junior doctors were allocated audits when they started in the department.
- The overarching governance framework was very strong and was led by a consultant with an excellent understanding of governance processes.

- Innovative approaches were encouraged and supported, and these had a clear focus on patient safety, quality and performance.

However:

- A departmental strategy had not yet been drafted and agreed, although this was a deliberate decision by the new clinical lead to allow time for staff and senior leadership engagement. The development of this strategy was planned to be clearly aligned with the trust quality strategy, published in July 2016, and to ensure the engagement of staff within the department.

Vision and strategy for this service

- There was a clear vision for the continued development of the department, however this was not yet written down. Managers and staff were able to communicate their vision to us, telling us the department wanted to continue its improvement of safe, quality care delivered in a timely manner.
- A local strategy for achieving the vision had not been produced or finalised. However, there was work ongoing to ensure that this was aligned with the trust quality strategy, published in July 2016, which set out the expected quality standards within the trust as well as associated behaviours which were in line with the trust values. There was agreement from all that this would have a heavy focus on staffing, particularly within the medical group, and continued engagement with partners. Staff engagement was seen as essential in the development of the strategy. There had been a number of innovative projects in place as part of this development including SHINE, REACT, a virtual ward and improved signage throughout the department.
- The clinical lead for the department had only been in post since September 2016 and had therefore not yet 'put pen to paper'. This had been a deliberate decision because they did not want to produce a new strategy quickly, without taking staff and trust priorities into consideration. They explained their intention was to draft a new vision and strategy in the new year following a senior management team away day. They told us this would allow the vision and strategy not only to meet the needs and desires of the department, but also the agreed direction of the trust. The full development of the vision and strategy would have staff input to ensure it also reflected their views and had their support.

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Governance, risk management and quality measurement

- There was a strong governance framework which was focused on supporting the delivery of safe, quality care. There were clear reporting structures from the department into the division and up to the board, and vice-versa.
- A departmental clinical lead for governance had been appointed who oversaw both governance arrangements and audit activity. This consultant had a strong understanding of governance and ensured all aspects of quality, safety, performance and finance were being considered.
- Fortnightly team and management meetings were well-structured. Standing agendas included performance, staffing, safety, governance, trust issues, complaints and clinical incidents, teaching and training. Minutes of the meetings were kept and detailed the discussions that had taken place.
- Regular mortality and morbidity meetings were also held and discussions were again well-documented in meeting minutes. Learning opportunities were identified and plans made to ensure staff received additional teaching and support as needed.
- A strong audit programme had been introduced and the areas of work had a strong focus on patient safety. Learning from clinical incidents was used to help develop some of the audit work. When middle-grade doctors started in the department they were tasked with an audit each in their first week. These were agreed and overseen by a lead consultant, and all relevant staff were involved. This included nursing, medical, administrative and support staff. Following the identification of a need to audit, the audit was allocated, designed and agreed. Once an audit had been completed the results, conclusions and recommendations were presented at a dedicated audit meeting. Actions were agreed to meet the recommendations and action plans put in place. Actions included changes to practice, administrative support (for example stickers on notes), teaching, and information posters, and usually involved a re-audit to check improvements were being made.
- The department had a local risk register, which was reviewed by the governance lead and matrons on a quarterly basis, or sooner if something had significantly changed. The risks recorded on the register reflected the

concerns staff and managers told us about. A divisional and trust risk register were also used so higher risk concerns could be reviewed at a more senior level in the trust. This was a score-based system and escalation was made by the management team as required.

- A sepsis lead had been appointed but they had started a new job. A new sepsis lead was due to be appointed in January 2016. There was evidence sepsis was a focus in the department, with a sepsis audit having been completed and information posters and teaching sessions taking place to raise awareness and increase performance.

Leadership of service

- The emergency department had an energetic, cohesive and well-motivated leadership team. The leadership team were highly visible in the department and regularly worked clinically. There was a clear focus from the team to deliver excellent, high quality and safe care. They all demonstrated the skills, knowledge, integrity and experience needed for their roles.
- The department's clinical lead had only been in post in that role for three months, but was an experienced member of the emergency department consultant team. They were supported by a stable nursing leadership team and together they were providing outstanding leadership.
- Staff told us they trusted the leadership team and found them supportive and approachable. They told us they were supported to report incidents to ensure learning could be identified and patient safety improved. They felt they could do this without fear of repercussion, and felt they would be listened to and supported through any investigations.
- All staff fulfilling a leadership role, including consultants and nurses in charge of the department, provided excellent support to their teams on a 'day-to-day' basis. We received lots of positive feedback from staff. Comments included: "The best managers I've ever had are here" and "I feel well-supported by my managers."
- Although the local leadership was excellent, some staff told us they didn't feel well supported by the divisional management team. They didn't feel the divisional managers engaged fully with the department. However, everyone told us there was excellent support and engagement from the executive team, including the chief executive.

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Culture within the service

- Staff told us they really enjoyed working in the emergency department. They felt respected and valued. Team work and a supportive, open culture were cited by many staff as one of the best things about working in the department, and this was clearly visible throughout our inspection. Morale was generally good despite high demand and crowding. Staff felt leaders recognised the pressures they faced and took a genuine interest in staff wellbeing.
- There was a culture of openness and honesty. Staff told us they felt able to raise concerns and believed they would be listened to and supported. They said this was the case across all staff groups and grades.
- Although reception staff and patient flow coordinators were not under the direct management of the department, they were well integrated and told us they were made to feel part of the team. They said staff were supportive of them and included them in team activities.
- A number of staff told us this was the best emergency department they had worked in, and put this down to the positive culture and teamwork, encouraged by the leadership.

Public engagement

- The emergency department engaged with patients in a number of ways. The main method of patient engagement was through the NHS friends and family test. Methods of collecting responses included touch screen surveys in the observation unit and waiting room, text messaging and postcards.
- During project work, patients were engaged and asked for their input where necessary. For example, during the SHINE patient safety assessment tool project patients were asked what they felt was important to them while in the department. Feedback about access to food and water and contact with relatives were subsequently included in the final checklist.
- Aside from the Friends and Family Test, the department had attempted to run its own regular patient survey but they had received such a low response rate it was discontinued.

Staff engagement

- There were some formalised staff engagement programmes, for example drop-in sessions and exit

interviews, but staff told us they could give open and honest feedback to managers at all times. Staff felt ideas and concerns were listened to and taken forward where possible.

- The trust also encouraged staff to complete the annual staff survey and we saw action plans had been written to address areas where improvements could be made.

Innovation, improvement and sustainability







- A number of innovative projects had been completed by the department to help improve patient care and the sustainability of the department.
- The SHINE patient safety assessment tool had come about following a research programme supported by the Health Foundation. This work had resulted in a patient safety checklist and its benefits to patient safety and experience are well-documented throughout this report. The project was nominated for two 2 Nursing Times awards and the checklist was being shared with and used by five other emergency departments in the region.
- Collaboration with external partners to help improve patient flow included the 'virtual ward' and REACT services. Both services looked to provide support to patients in the community so hospital beds could be released. We were told the virtual ward had just hit the 200 patient milestone, saving the hospital 2,000 bed days.
- A multidisciplinary and high impact users group had been established to help review and support some of the most frequent attenders to the emergency department. The group worked to develop personalised care plans for these patients to improve their health outcomes and link them with community services relevant to their complex health care needs.
- Having recognised the high levels of abuse to staff in the waiting room and the lack of information about how the emergency department worked, a project with the Design Council was nearing completion. New signage had been designed to make it clearer to patients how each step of the journey through the department worked and what they could expect. This was due for completion in December 2016.
- A touchscreen system in the resuscitation area had been designed by one of the consultants in the emergency department to make emergency protocols and

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guidelines readily available in a simple and fast way. Staff were able to see these at the bedside and they could be used to support timely treatment pathways in fast-moving emergency situations.

- The department used simulation training to embed learning from incidents.

Medical care (including older people's care)

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

We inspected the medical division of University Hospitals Bristol services at University Hospitals Bristol Main Site (Bristol Royal Infirmary, Bristol Haematology and Oncology Centre and the Bristol Heart Institute).

The medical care service at University Hospitals Bristol Main Site provides care and treatment for Cardiology, Dermatology, General Medicine, Geriatric Medicine, Hepatology, Haematology, Oncology, Respiratory Medicine, Rheumatology and Stroke Medicine. There were 361 medical inpatient beds and 71 day-case beds located across 16 wards. There were nine medical wards, a medical assessment unit and discharge lounge in the Bristol Royal Infirmary. The Bristol Heart Institute which is part of the hospital had one ward for medical patients, one ward for cardiology patients, another ward for cardiology and cardiac surgical patients and a coronary care unit. The Bristol haematology and Oncology centre (also part of the hospital) has an oncology day unit, one clinical oncology ward with teenagers and young adults facilities, an acute oncology assessment area, a clinical haematology ward and a haematology day unit and assessment area.

In July 2016 in medical services there were 346 nursing whole time equivalent (WTE) staff employed and 205 other clinical WTE staff. The trust had 36,206 medical admissions between September 2015 and August 2016. Emergency admissions accounted for 21,231 (59%) and 14,975 (41%) were elective. The most three common

departments patients were admitted to were Gastroenterology, with a total of 6,251 (42%), followed by 3,160 (21%) for Cardiology and 2,274 (15%) for Dermatology.

Within Bristol Royal Infirmary, we visited 12 wards and departments including the medical assessment unit (MAU), medical wards, hepatology ward, respiratory wards including the higher care respiratory ward and elderly care wards including the elderly care assessment ward. We also visited the ambulatory care unit, stroke unit, discharge lounge and cardiac catheter laboratory.

Our visits included the Bristol Heart Institute which had one ward for medical patients, a cardiology ward, a further ward for both cardiology and cardiac surgical patients, a cardiac catheter laboratory and a coronary care unit. We also visited the Bristol Haematology and Oncology Centre with the oncology day unit, one oncology ward, which included a teenage and young adult facility, an acute oncology assessment area, a clinical haematology ward and a haematology day unit and assessment area.

We spoke with 35 members of staff, including nurses, doctors, pharmacists, therapists, administrators and hotel staff. We spoke with 30 patients and seven relatives. We reviewed 29 sets of patients' notes to identify the care being provided. Both prior to and after the inspection we reviewed information from the trust.

Medical care (including older people's care)

Summary of findings

We rated this service as good because:

- Medical and nursing staff told us there was a good incident reporting culture and they were actively encouraged to record incidents onto the electronic incident reporting system. Staff told us learning from incidents had led to changes in ward practice, such as an initiative to reduce patient falls. We saw evidence of duty of candour being understood and followed by staff members with a particular example of the trust policy being followed during this inspection.
- Safety was monitored and actions taken to improve safety. Staff created a system to ensure changes in patients' treatments and medicines were noted by staff and acted upon. The implementation of a 'bicycle light' system in the medical assessment unit ensured safety systems were strengthened, by prompting action from staff when patients' medicines were prescribed.
- Staffing rotas demonstrated staffing levels were in line with the hospitals staffing measurement tools, with agency staff used when required to cover increased demand and vacancies. Staff told us they considered staffing levels to be safe.
- Feedback from patients and those close to them was positive. Patients were treated by kind, caring staff who were respectful and considerate. Patients' privacy and dignity was respected and staff sought permission before carrying out care and treatment. Patients' emotional and social needs were valued and this was demonstrated in the way staff cared for patients, and in patient feedback.
- Staff often went out of their way to meet the emotional and physical needs of patients. It was clear they had taken the time to get to know and understand patients as individuals.
- The systems of escalation to ensure a constant flow of patients through the hospital were responsive to the ever changing demand. The service delivered was flexible and creative to ensure flow was maintained. During times when high numbers of medical patients were being admitted, the flow of patients through the medical division was monitored to minimise the numbers of patients who were

admitted to non-medical wards. These patients were known as medical outliers. The systems put in place to support the patients on outlying wards ensured they were seen by the right medical team every day, and their care was always overseen by the medical team.

- Services were planned and delivered in a way that met patients' needs, which included during times of increased demand. These included services such as the ambulatory care unit, a nurse-led clinic for transient ischaemic attack (stroke) and a virtual ward.
- The trust ensured it provided services to support patients' physical and psychological needs. Work had taken place to deliver services that meet the needs of patients living with dementia.
- Patients' care and treatment was planned in line with current evidence based guidance. Clinical care pathways and trust policies were developed in accordance with national guidelines and strategies.
- Patients mostly had comprehensive assessments of their needs. Patients had their pain assessed regularly and managed promptly. Their nutrition and hydration was assessed and monitored.
- The hospital achieved good patient outcomes and delivered effective care. A programme of local and national audits were used to monitor care and treatment was being provided in accordance with national guidelines. Some areas showed improvement, including the national stroke audit.
- Learning needs of staff were identified and training put in place to meet those needs. Practice education facilitators were available to support staff and specialist nursing teams provided individual and group teaching for areas identified as needing extra support.
- Patients received care from different teams who worked together to coordinate care. Multidisciplinary working was evident in all areas of the hospital. For some wards, complex discharges were daily occurrences and we observed board rounds taking place on wards, which demonstrated effective multi-disciplinary working. There were links with GPs and community providers to ensure safe patient discharge.

Medical care (including older people's care)

- Staff had access to patient information to deliver effective care and treatment. When patients who needed specialist community support were discharged, effective links were made with community services.
- Whilst care was provided seven days a week, ward rounds by medical staff did not take place every day. However, access to medical care was always available. Nurse specialists were available between five and seven days a week.
- Patients consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- Discharge delays, transfers and bed moves were all monitored to ensure they did not negatively impact on patients.
- Complaints were handled in accordance with trust policy, and improvements were made in response to complaints.
- There was a clear, overarching statement of vision and values for the medicine service, which was driven by safety and quality. The medicine division and specialised services divisions' vision and strategies were developed within the context of this. Staff understood the vision and strategy and their role in delivering it. They were proud to work for the hospital and were patient focused. Staff demonstrated a kind culture, both to patients and relatives, and to each other.
- Governance structures were complex to follow. However, the board and other levels of governance within the medical division functioned effectively and interacted well. Staff assured us risk was escalated when needed and the information communicated to the hospital board flowed well. Processes were in place to monitor, address and manage current and future risk. Performance issues and concerns were escalated to the relevant committees and the board.
- Leaders understood the challenges to good quality care within and outside the organisation, and there were collaborative relationships with stakeholders.
- Staff felt leadership was good and divisional lead staff were accessible. Staff told us they felt supported

and heard, and there was a collective culture of openness to drive quality and improvement. Leaders and staff demonstrated the participation and involvement of people who used the service was important to them.

- The hospital had forged strong links and worked closely with the voluntary sector.
- Leaders demonstrated a drive for continuous learning and improvement through the ongoing evaluation and monitoring of the service and by delivering projects and innovative developments aligned to this.

However:

- Systems were not always reliable to keep patients' information safe. Records were not consistently stored securely. This could cause a potential breach of patients' confidentiality.
- Not all medical staff received mandatory training in line with the trust's targets.
- Doctor induction was undertaken in scheduled blocks. Should doctors start work in between those blocks, they may work for a period of time without induction. This meant no fire training had taken place and should an incident occur, may place both staff and patients at risk.
- There were gaps in information being monitored in specific areas of care. For example, there were no pain audits to establish if pain was managed effectively for patients with an ability to express their pain. The cardiac catheter laboratory used a World Health Organisation surgical safety checklist for all surgical procedures. However, these records were not audited to ensure they were all fully completed.
- Not all staff had received an appraisal in the last year. Without an appraisal, learning needs may not be identified and a plan put in place to support staff to develop their practice.
- The management of risk did not protect staff on the hepatology ward. Senior staff were aware of risks for patients and staff but did not put the required processes in place to mitigate the risk and ensure safety. This related specifically lone working practices

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when accompanying patients off the ward at night who wanted to smoke. We raised this with the trust who agreed to implement a process to ensure this risk was reduced.

- The division had recognised a risk in the acute oncology service at night, concerning both staffing levels and a lack of suitably skilled triage staff. However, further action was required to minimise the risk to patients in both the service provision and staffing provision.

Are medical care services safe?

Good



We rated safe as good because:

- Nursing and medical staff felt there was a good incident reporting culture and they were actively encouraged to complete electronic incident reports. Staff told us learning from incidents had led to changes in ward practice.
- The duty of candour was understood by staff. When things went wrong, patients were provided with a timely apology and support. Openness and transparency about safety was encouraged.
- Safety data was monitored and incidents were investigated fully to enable risks to be identified and to provide an accurate picture of safety.
- Staff implemented safety systems such as a 'bicycle light' system in the medical assessment unit which ensured medicines changes happened promptly to ensure safety systems were strengthened.
- Staff took a proactive approach to safeguarding and were aware of local safeguarding procedures.
- We observed and patients told us wards and departments appeared visibly clean. Staff were seen to use personal protective equipment that prevented infection.
- Medicines such as controlled drugs and refrigerated medicines were stored appropriately. We saw evidence which showed medicines errors were audited and incidents and themes were visible at board level. Learning from incidents was identified. Medicines administration records were well completed.
- Staff in most areas completed comprehensive risk assessments for patients and developed management plans to ensure risks to patients' safety were monitored and maintained. Risk assessment processes were monitored and we saw evidence learning from audit was implemented.
- Staffing rotas demonstrated staffing levels were in line with the hospitals staffing measurement tool, with agency staff used when required to cover increased demand and vacancies. Staff told us they considered staffing levels to be safe.
- Medical staffing levels and skill mix were well planned and ensured safe care at all times.

Medical care (including older people's care)

However:

- Systems to ensure patients' information was kept safe were not always implemented. Records were found to not be stored securely in a quarter of the places we visited which could cause a potential breach of patients' confidentiality.
- Not all staff received mandatory training in line with trust policy. Shortfalls were seen in training levels for medical staff.
- There were gaps in the monitoring of surgical checklists and in auditing pain management. The cardiac catheter laboratory used a World Health Organisation surgical safety checklist for all surgical procedures. The records were not audited to ensure they were all fully completed.
- Doctor induction was undertaken in scheduled blocks. Should doctors start work in between those blocks, they may work for a period of time without induction. For those staff, this meant no fire training had taken place and should an incident occur, may place both staff and patients at risk.

Incidents

- Incidents were reported by staff with lessons learnt and improvements made when things went wrong. Nursing and medical staff told us there was a good incident reporting culture and they were actively encouraged to complete electronic incident reports. Staff we spoke with were aware of their responsibility to report incidents and received learning from incident investigation.
- The trust policy set out the procedures for managing incidents. Staff told us the policy was accessible and they understood and followed it. Staff understood the root cause analysis process of investigation and their roles and responsibilities in carrying out this type of investigation.
- Senior nurses had oversight of incidents and investigated any concerns. When staff reported an incident on the electronic incident recording system, they received an email acknowledging and thanking them. Once an investigation was complete, staff received a report of any actions or outcomes associated with the incident.
- Incidents were investigated and learning from them shared. We reviewed a large number of staff reported

incident data prior to the inspection. We saw incidents were investigated and learning fed back to staff in the medicine division, and to the wider hospital, when applicable.

- Learning from incidents led to changes in practice. For example, staff break patterns were changed as a result of learning from incidents related to medicines administration. The changes ensured a nurse assistant was present during drug rounds. This meant a nurse assistant was always available to attend to patients' care needs and prevent interruptions to staff administering medicines, in order to reduce the likelihood of errors. On cardiology wards, we heard how learning from two root cause analysis (RCA) investigations was implemented on the wards to improve patient safety. One had resulted in a falls protocol being placed in every bay.
- Learning from incidents was shared with the wider hospital through the safety briefing. This was a staff discussion at each hand over which enabled immediate dissemination of information and learning. For example, following an investigation into a fall, we saw a record that the outcome was shared with the ward. As a result of this incident a poster was laminated and put in the toilets to remind staff of preventative actions they could take. Staff told us they considered patient safety had improved as the briefing system had evolved.
- The hospital reported 12 serious incidents in medical services between October 2015 and September 2016 which met the reporting criteria set by NHS England. Of these, the most common type of incident reported was slips, trips, or falls (10 incidents). There was also one pressure ulcer and one further incident pending review.
- In order to drive quality and safety improvements across the division, senior divisional managers told us learning from incidents such as pressure ulcers, falls and serious incidents were shared through the quality and outcomes group or by the head of nursing for the division. Staff confirmed this information was passed to them and we saw handover sheets and briefing notes which confirmed this.
- Mortality and morbidity meetings took place for most areas of the hospital. The minutes were recorded and learning shared with wider management groups, including the clinical governance and risk management meetings.

Duty of Candour

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- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- The trust policy 'Staff Support and Being Open Policy (Duty of Candour)' updated June 2016 provided staff with information for undertaking their duty of candour.
- We spoke to 20 staff in various roles who all demonstrated an understanding of the duty of candour. We were given an example of a recent event which had triggered an investigation and an immediate use of the duty of candour. The trust's 72 hour report form and root cause analysis investigation form contained a prompt for staff to complete initial duty of candour where necessary. We saw staff were following the policy, by meeting with family for further discussion of the incident and to provide an apology.
- Medical staff had a separate induction programme with a patient safety session, which contained the same content for duty of candour as for other clinical staff. Duty of candour training formed part of the induction training for nursing staff.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Data collected on a monthly basis provides immediate information and analysis to teams to monitor their performance in delivering harm free care.
- Each ward collected data in line with the patient safety thermometer methodology and displayed the results on a notice board called 'how are we doing'. For example in October 2016 the medical assessment unit had achieved 99.2% hand hygiene compliance and recorded eight falls.
- Data from the Patient Safety Thermometer showed the trust reported 4 pressure ulcers, 7 falls with harm and 20 catheter urinary tract infections between November 2015 and November 2016. Rates of incidents across all three areas declined during this period.
- There was a recognised risk that venous thromboembolism (VTE) may not be recorded correctly and so patients may be at a higher risk. The trust risk register recorded that VTE risk assessment compliance

had decreased from 99% in the first six months of 2015 to 97% in January 2016. The risk register also recorded evidence that the process for data entry for VTE risk assessment completion by non-clinical staff may have resulted in unreliable compliance information. We looked at VTE assessment within patients' records and saw they were all fully completed.

Cleanliness, infection control and hygiene

- There were systems and processes to reduce and control the risk of cross infection. All wards and departments we visited appeared visibly clean and cleaning staff were seen throughout the hospital managing the cleaning rotas.
- Ward staff in all areas we visited wore the correct uniform and used personal protective equipment, gloves and aprons as needed. Staff followed the hospital policy of being bare below the elbow.
- However, hand hygiene practice was not consistent across all wards. On a small number of wards staff did not adhere to policy for hand hygiene. We observed some wards did not have clear hand wash signage and available hand gel. On ward A400 we observed 15 hospital staff enter the ward, only four used the antibacterial hand gel prior to entry. Ward A525 did not have hand gel available on entry to the ward. Ward A528 did not have any signage to inform the general public about the importance of hand washing before entering the ward. Other wards had hand gel available and we observed staff cleaned their hands on entry to the ward.
- Wards maintained cleaning audits which were displayed at ward entrances. Scores were high with an overall compliance percentage score. For example, in October 2016 ward 808 achieved 98% and ward 528 achieved 96%. We observed cleaning staff were thorough and worked throughout the day to maintain cleanliness.
- There had been no cases of methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia associated with care and treatment of patients at the trust since August 2015.
- There was an average of three cases of *Clostridium difficile* per month reported over the previous 13 months ending November 2016. The trend shown a decline in reported cases over this period and was in line with the England average.
- All staff received mandatory and ongoing updates on infection prevention and control. Other ad hoc and

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targeted training sessions were held. For example, an infection prevention and control study was held in July 2016 in the dental hospital for trust staff. The theme of the study day was 'back to basics'.

- Quality assurance audits were undertaken on an ad hoc basis and were facilitated by the infection prevention and control team. The audits observed staff and their practice. All areas that were audited had their results fed back to the nurse in charge at the time of audit, followed by an email to the ward manager, matron and head of nursing. The most common themes were inappropriate use of personal protective equipment, the doors on the isolation room not being kept shut, and signs on doors to identify isolation rooms not completed. Staff were informed and any teaching required was immediately instigated. Areas of audit for July and August 2016 included specialist medical wards and wards providing care to older people.
- We saw when side rooms were used for the isolation of patients with an infection, systems were in place to inform staff of what level of protection and isolation was required to maintain safe hygiene practices.

Environment and equipment

- Access to equipment and facilities kept patients safe. Staff had easy access to equipment and we saw equipment had been serviced and labels applied to identify when servicing was next due.
- Resuscitation trolleys in all areas we visited were seen to be checked daily and all equipment serviced within the timescales required. In the cardiac catheter lab, staff had used a highlighter to mark the 'use by' date on equipment, which made it easier to see and ensured items were replaced in a timely way.
- We reviewed the maintenance records of equipment in the medical division and saw some equipment due for annual service in 2012 and 2013 had not been recorded as completed, despite a maintenance schedule noting a frequency of every 12 months. This equipment included two syringe drivers and an infusion pump. We looked at equipment maintenance and service stickers attached to all equipment as we inspected, and all equipment we saw was in date. We did not see any drivers and pumps out of date.
- The call bell system on ward 515, the stroke ward, did not function correctly. When pressed by a patient the call bell rang quietly but did not show on the digital display screen to inform nurses where assistance was

needed. The bay was identified from the nurse's station but not which patient and so may delay the nursing staff identifying which patient needed assistance. Nurses could see the call bell light at each bay entrance. Maintenance staff were aware of the issue but we were told by the nursing staff the issue was too expensive to repair.

- Staff on cardiology ward 705 told us there was a shortage of cardiac monitoring equipment for which a capital bid had previously been rejected. Whilst this did not make the ward unsafe, there were occasions when equipment had to be borrowed from other wards. The monitors for this equipment were linked to the ward from which they were borrowed. Staff from the other ward would alert staff if an alarm sounded. This equipment did not provide a print out of the heart rhythm.
- On the coronary care unit, the information technology system connected directly to ambulances so staff could see the ECG (electrocardiogram) results for patients in an ambulance on the way to hospital. An ECG is the heart trace used to assess the heart's rhythm and electrical activity, particularly during a suspected heart attack. Being able to see the ECG whilst the patient was on route to the hospital helped staff to make more informed decisions and gain faster access to the right care and treatment.
- The environment and facilities on most wards in the hospital were well maintained. However, the decor on the oncology ward was in need of refurbishment and staff told us they had raised this at a divisional level. We were told this was one of the few wards in the hospital that had not received any level of refurbishment since it was built.
- The cardiology and coronary care units were well laid out. There were specialised rooms and equipment in the haematology and oncology wards to deliver safe care and treatment, such as treatments rooms that required clean air ventilation, to reduce the risk to patients with compromised immunity. These rooms had a side room for staff to change into protective equipment and staff, including cleaning staff, had a clear understanding of the protective equipment needed.
- Staff raised concerns about the lack of space in the haematology day unit and assessment area (D701) where levels of planned and unplanned patient care needs fluctuated. On occasion, this meant patients

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would choose to stand in the corridors whilst waiting for treatment. They were reluctant to sit in the busy waiting room due to risk of infection and low immune system suppression as a result of their treatment.

- Whilst the design and maintenance of facilities on the whole kept people safe, there were some areas of risk identified in relation to access to two wards which may have compromised patient safety.
- Concerns were raised by staff on ward D703 about the heating system as the temperature fluctuated and both staff and patients often felt too hot or too cold. Staff on the ward were unable to adjust the heating controls and had reported the issue to the maintenance helpdesk but a response to this had been slow and had not resolved the problem. This could have impacted upon the health of both patients and staff.
- The environment for patients on the oncology ward did not ensure patient safety for patients who may be confused or could not maintain their own safety. At the end of the ward was a door to a staircase which would be used by staff and was accessed by pressing a button on the wall, no other security was in place. The staircase was out of sight but easily accessible. We alerted staff to this risk.
- Access to the hepatology ward was controlled by use of an intercom system. The intercom system was not fully understood by staff and this impacted on people trying to get into the ward causing delays and confusion to those waiting outside the ward. We attempted multiple times to access the ward, and as part of the process were able to hear nurse's conversations on the ward. We asked staff about the system. It appeared the telephone intercom handle had not fully connected and so allowed us to hear ward conversations at the nurse's station. This may breach patient confidentiality as nursing staff used this area to discuss patient care.
- The staff room on the medical assessment unit was not secure and could allow access to unauthorised people. The door was secured by a key pad, but the key pad was not operating to prevent access and the door could be pushed open. No lock was in place to ensure the security of staff bags and belongings. Hot water from a boiler was accessible in the same staff room, which placed confused patients on the medical assessment unit at risk.
- Substances which could be harmful to health if ingested were not always stored safely. The storage of chlorine tablets in ward unlocked sluices on the medical

assessment unit, wards A808, A805 and hepatology, D202 and C805 meant they were accessible to patients who may be confused and could be ingested. We informed the trust of this risk at the end of the announced inspection. We returned on 1st December 2016 as part of our unannounced inspection and found the storage had not been improved and the chemicals were still accessible. For example we saw on the medical assessment unit in an unlocked stock cupboard which was opposite patient side rooms, 36 tubs of chlorine tablets, each of which contained 150 tablets. We also saw when the chlorine tablets had been diluted into a water coloured solution they were labelled with the name of the product but no instructions not to be ingested.

- The hepatology ward had a sign advising staff 'Actichlor tablets were to be kept in the cupboard in the sluice - no need to lock in the cupboard/sluice'. Staff were unclear why they were advised to do this. However, the staff on duty recognised the risk this presented to patients on the ward, such as those who were confused and were withdrawing from alcohol, by having access to unmarked fluids in unlocked rooms. We raised the risk with staff.

Medicines

- Medicines were managed in a way that kept patients safe across medical services, with most medicines stored securely.
- Some wards had 'pods' by each bed which stored patients' medicines which nurses assisted patients to administer when needed.
- Medicines administration records were seen to be well completed and recorded patients allergies. Medicines which were needed 'as required' were recorded clearly with instructions for staff about doses and range of administration.
- Controlled drugs were stored securely. The controlled drugs registers were up-to-date and the access to the cupboard keys was only by authorised staff. On the stroke unit, five sets of keys were available and staff recorded for each day who had held all of the keys during each shift. This provided a clear audit trail of which staff had access to which medicines.
- We saw medicine fridge temperatures were monitored on each ward and all were within the expected range. On ward D703 the medicines fridge had broken and staff were using a backup fridge.

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- Medicines were available to enable staff to treat patients with a diabetic hypoglycaemic event quickly. They were stored in 'hypo boxes' which were located in the locked clean utility rooms on the wards.
- Following a staff suggestion a system was implemented on the medical assessment unit to inform staff of changes to medicines and treatment. This was because doctors made changes to patients' medicines and treatments, and staff were sometimes not aware of these changes. This had led to delays in treatment. In order to alert staff to a change, bicycle lights were fitted to notes boxes outside each bay. When the doctor made changes they put notes in the boxes and switched on the red flashing light. Staff responded to the light and acted on the changes. Staff told us this had been successful in reducing the number of missed treatments.
- However, on the higher care respiratory ward and ward A605 medicines such as creams, gels, enemas and suppositories were kept in the sluice. These medicines were not named as prescribed for a specific patient and were kept as stock in a dirty utility room instead of a clean area. The rooms were accessible without a lock, the creams were not stored in a locked cupboard and the rooms' temperature was not controlled or monitored. This meant they were not kept in an area free of contamination, or was tamper-proof, or stored at a temperature which was essential to ensure the medicine remained effective.
- We saw evidence which showed medicines errors were audited and incidents and themes were visible at a board level. Lessons from incidents were identified and learning shared.
- The highest number of incidents reported trust-wide were associated with medicines. The level of incidents had been relatively stable between December 2015 and March 2016.
- Medicine errors related to diabetes, including hypoglycaemic events, were not directly reported to the diabetic specialist nurse team at the time of the incident, to identify if further training was needed. Those incidents were reviewed by the medicine steering group from which the diabetes specialist nurses received the information and took any required action. Should there be any immediate concerns; the diabetes specialist nurses were informed.
- Some nursing staff had training to prescribe medicines as part of their specialist training. For example, the specialist stroke nurses were qualified nurse prescribers which enabled treatment to progress quickly.
- Patient group directives are a legal framework developed to allow some health care professionals to prescribe or administer medicines without the need for a doctor or pharmacist. The trust's patient group directive for first dose of antibiotic initiative allowed nurses to administer the first dose of antibiotics in neutropenic patients. This was in line with a protocol validated by clinicians, pharmacists and microbiologists. The trust told us this reduced the crucial door to needle time in this emergency setting, as per National Institute for Health and Care Excellence (NICE) recommendations, improving outcomes in patients.
- A patient group directive was also developed for first dose analgesia (pain medicines), which allowed nurses to administer first dose of diamorphine to patients presenting in acute sickle crisis, based on a protocol developed by clinicians, nurses, pharmacists and palliative care team. This improved patient care and helped achieve the NICE recommendation of '30 mins to first dose analgesia in sickle painful crisis'.
- As part of a wider pharmacist role linked to the falls work being undertaken by the trust, the lead pharmacist was involved in medicine reviews of patients who had fallen. The information gathered from these reviews fed into e-learning for prescribing.
- There was a pharmacist allocated to the discharge lounge. Take home medicines were pre-arranged on the ward but on some occasions extra pharmacy support was needed. The lounge staff used a pharmacy tracker on the computer to follow up discharge medicines. The discharge lounges had medicines kept in a locked cupboard behind the nurses' station and had a minimum stock level. There was no resus trolley available in the discharge lounge but an emergency box was in place containing emergency drugs. Suction, oxygen and observation equipment were in the discharge lounge, as well as a panic button to alert staff in an emergency.
- We saw some delays in the process for the delivery of discharge medicines and medicines administration records. In the higher respiratory ward, three patients were waiting for the delivery of medicines and their medicine charts before they could be discharged. The

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medicines had been prepared by the pharmacy but were delayed in being returned to the ward by the pharmacy porter. The porter had a delivery route which took considerable time. The patients had been waiting in excess of four hours. The turnaround times for take home medicines were audited. For September 2016 the average time was 81 minutes. Whilst this was within the trust target, the delay appeared to be with the delivery process and not the administration of the medicines.

- Processes for medicines management and delivery on the chemotherapy day unit were reviewed in 2016 as part of the chemotherapy day unit transformation project. Consultants were involved in work to reduce prescription queries and improve administration processes through a series of education sessions. The work involved administrative, nursing and pharmacy staffing to review and learn from individual cases. Ongoing auditing of prescribing queries was taking place, in order to tailor specific learning sessions.
- There were disposal and destruction processes in place for wasted or out-of-date medicines on each ward. Wasted medicines were disposed of on each ward and destruction could be arranged through the pharmacy.

Records

- Patients' individual care records were not consistently stored and managed in a way kept patients safe.
- The completion of patient records varied between departments. Some were well completed, for example the stroke unit. However some records did not have risk assessments fully completed and were not fully legible.
- We looked at 26 patient records. Records were divided into two sets for each patient, one set contained the doctor's notes, therapist input and details of all investigations and the second set remained with the patient and included observation records, care plans and risk assessments. The records varied in their standard of completion. We saw some medical staff writing was not clear.
- We looked at risk assessments which were undertaken for each patient and were recorded in a risk assessment booklet. These included risks relating to food and fluid intake, VTE and environmental risks. We saw these assessments were not consistently completed for each patient, with four out of 26 booklets being partially completed, with no explanation as to why some risks were not assessed.

- Records were not stored securely on all wards. On four out of 16 wards (ward C808, the medical assessment unit, the higher care respiratory ward and the stroke ward) notes trolleys were in place but were not locked when left unobserved. There were unsecure records left waiting for collection on desks, in boxes and all were accessible to the public or patients on the ward.
- On Ward D703 the patient records trolley lock had been broken for two weeks. On ward C805 a trolley containing patient records was left open in a bay without a member of staff present and a computer monitor was left unattended which had patient data that was visible. This monitor was quickly closed down by a member of staff who returned promptly to the bay.

Safeguarding

- Whilst there were reliable systems in place to monitor safeguarding processes within the hospital, and staff we spoke with knew how to raise and recognise and report safeguarding concerns, mandatory safeguarding training levels were not being met. The trust set a target of 90% for completion of safeguarding training which they had not met. Medical staff at the hospital were reported to have undertaken two safeguarding courses and training completion was less than 90% of target for both courses.
- Staff we spoke with were able to explain fully their responsibilities when identifying safeguarding risks and felt supported to raise any safeguarding issues. Dementia training was now included in the safeguarding training for all staff.
- The trust safeguarding activity and arrangements were monitored by the trust's safeguarding steering group. It was chaired by the chief nurse and included senior divisional representation. The group reported to the clinical quality group, which in turn reported to the quality and outcomes committee and subsequently to the trust board, to ensure they were aware and updated with any safeguarding issues.
- Staff received training in female genital mutilation to ensure actions were taken to support those patients. Further literature was also available in the staff rooms of some wards to support patients and staff.

Mandatory training

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- A programme of mandatory training was provided for all staff. The trust set a target of 90% for completion of mandatory training which they had not met in all areas including fire safety, safeguarding and resuscitation.
- Training completion rates as of the 1 May 2016, for medical and dental staff, were below the 90% target for conflict resolution awareness (72%), infection control (64%), information governance (39%) and manual handling (57%), resuscitation 73%, fire 84%, safeguarding level 3 65%.
- For nursing and midwifery staff, training completion rates were above the 90% target for conflict resolution awareness (99%) and infection control (95%), but below the 90% target for information governance (75%) and manual handling (87%).
- Reasons given by staff for lack of completion of mandatory training were attributed to them being provided with little study time, wards being busy or training which should have been provided on induction was not received.
- Nurses could see their training status via an electronic system which had a traffic light to alert staff to approaching lapses in validity. The senior sister received updates of these dates and emailed staff to prompt them to update their training. Staff told us they were allocated an extra 12.5 hours per year to maintain their mandatory training. Should they not complete all areas of mandatory training, they would lose the 12.5 hours from their annual leave
- Training was noted on the risk register to be an area of moderate risk. The trust-wide risk register identified a risk of not providing resuscitation training to the most appropriate staff within the trust, leading to a resuscitation skill gap for clinical staff. The risk was assessed as low risk but also noted in February 2016 to require further work to ensure all staff were suitably trained. Basic life support training was provided as part of the trust induction and a review of who had completed advanced life support training was taking place across the division. Divisional management for the hospital informed us compliance with resuscitation training was at 80% at the time of the inspection. They reported compliance had improved since this training was added to the staff induction training programme, and ongoing training was being delivered to ensure all staff were suitably trained. The level of training was monitored but no date was available for when full compliance would be met.
- Fire training was also not fully completed by all medical and nursing staff. This meant not all staff both during the day and overnight had completed either face to face or e-learning fire training.
- The system in place noted in the first year of employment, face to face fire training was needed. In the second and third year, online training was undertaken, and in the fourth year, face to face training was required. The staff training matrix provided by the trust noted more nursing staff had received fire training to a greater extent than medical staff. Some medical staff had very low achievement levels. For example, medical staff on the older persons' ward had a completed fire safety training level of 43% and general medicine medical staff 20%. Medical staff in respiratory medicine achieved 40% compliance, and hepatology medical staff 25%.
- Essential 'specific to role' training was which was deemed by the hospital, as essential to staff at a departmental and/or individual role basis. The trust was aware it did not have a system of centrally recording, identifying, or governing all of this training. This presented a risk to patient and staff safety, as there may be untrained staff working at the trust. We spoke with specialist nurses who advised us they did provide specialist support training to staff, when it was identified as needed.

Assessing and responding to patient risk

- Staff carried out comprehensive risk assessments for patients and developed management plans to ensure risks to patients' safety were monitored and maintained.
- A system of national early warning scores (NEWS) was used in the hospital to alert staff to the deteriorating patient. The National Early Warning Scores (NEWS) was implemented in 2015. This is a nationally recognised scoring system allocated to physiological measurements. We looked at 20 NEWS charts and saw NEWS were correctly calculated and the escalation process correctly followed. All resuscitation training had been amended to include more focus on early warning scores.
- The scores alerted the nursing staff when there was a need to escalate a deteriorating or unwell patient to the medical team. We saw when a patient's observations highlighted deterioration in their physical condition; the nursing staff had consistently and responded to these scores.

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- The trust risk register identified the risk of patients coming to harm or having sub-optimal outcomes due to the failure of clinicians to recognise and respond to deterioration. As of 07/12 2016 this was identified as a moderate risk with actions ongoing.
- The trust undertook an audit of NEWS in September 2016 to monitor its use. The medicine division audit included 11 wards and consisted of 55 patient charts. One of the recommendations of the completed report was training and education focused on correct escalation (when and to whom to escalate), and a further refocus on maintaining competence by conducting manual observations once a day in general ward areas.
- The auditing of NEWS was reviewed at clinical governance meetings. In the November 2016 clinical governance meeting minutes for the haematology and oncology department noted two incidents where elevated NEWS scores were not responded to. This was flagged as a divisional risk. A simulation training package was being developed and it was raised as an action that further training needed to be rolled out to staff, as part of the trusts ongoing training programme in NEWS.
- The trust had a sepsis audit and work stream to improve the prompt recognition and treatment of sepsis and reduce the incidence of deteriorating patients due to sepsis.
- A sepsis screening tool was in place as part of the NEWS record. There was no specific sepsis lead role identified but training was provided to all medical and nursing staff to raise awareness of sepsis. Through the staff safety bulletin, all staff were reminded to follow the NEWS escalation process and ensure sepsis treatment was started within one hour.
- In the medical assessment unit most patients were seen and assessed by a relevant consultant within 12 hours of admission. If patients were considered high risk they would be seen by one of the medical doctors on the unit and a consultant if needed. The timescale to be seen by a doctor from GP referral was two hours, to be seen by a member of the medical admissions team. If a patient was unwell or scored highly on the early warning scores, nursing staff would consult with medical staff, or medical staff from the admissions team (known as the 'take team') and discharge team, to ensure the patient was seen urgently.
- Patients suffering from neutropenic sepsis were admitted directly onto the acute oncology ward at any time during the day or night if they became ill. These were patients receiving treatment for cancer, who were at increased risk of an infection due to their treatment. A four bedded bay, part of ward D603, was allocated for neutropenic sepsis patients and for patients experiencing serious side effects of treatment that had been delivered in oncology or haematology. These acute oncology patients accessed care through a triage process by calling a designated phone line.
- The stroke pathway had been developed to ensure patients who had suffered a stroke were seen immediately by appropriate staff, and treatment commenced promptly after arriving at the hospital. Specialist stroke nurses were available to attend the emergency department and stay with the patient to ensure they were continually monitored.
- Ward A525 was a higher care ward caring for patients with increased respiratory needs, such as those requiring non-invasive ventilation. This ward was previously the intensive care ward and so was laid out in single bays with some side rooms. The area was divided into male and female areas but mixed sex breaches had taken place when higher care needs had been provided. On these occasions apologies were made to patients for toilet and bathroom access. Staffing levels were calculated to manage up to eight patients with increased needs and still have sufficient staff available for the remainder of the ward. Staff were confident the staffing levels were safe and enabled two patients to one nurse when patients were classed as a category two level of higher care. There were sufficient staff available to cover all breaks and the supervisory sister was also available to support staff as needed during the day. We visited the ward at night, when staff assured us the staffing levels remained safe.
- Non-invasive ventilation (NIV) is the administration of ventilator support without using an invasive artificial airway. This was well managed at the hospital to ensure patients only received this treatment with correct support. NIV was managed by consultants and patients were moved from their place of care to ward A525 if NIV was needed. This was to ensure staff with the right skills were providing this specialised level of care. Systems were in place to ensure those staff were made aware of any patients needing NIV and prevent the risk of this being provided elsewhere in the hospital.

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- On every board round we saw staff reviewed patients' risk assessments such as falls, nutrition, and mental capacity and these were reviewed and adjusted as the patients' condition changed. Staff used specific, recognised icons against the name of each patient, which alerted staff to a specific risk. For example, the icons identified a patient at risk of falls, with specific nutritional needs or patients who were living with dementia. The system was ticked when a referral had been made to a specialist team, for example specialist respiratory nurse or to the therapy team. Risks were also recorded in each patient's notes and were completed to a varied level.
- Should a patient within the medical division have a cardiac arrest, staff would commence resuscitation and also call the 'crash team' to provide resuscitation assistance. The medical assessment unit had four high visibility beds with monitoring available and portable monitors for other beds, to ensure ongoing monitoring of the patients' condition.
- Divisional managers informed us some ward layouts were changed to make them safer and enable better monitoring of patients, in order to identify changes in their condition. For example, in order to reduce violence and aggression on the hepatology ward, patients were now in one, two or four bed bays which provided a quieter and calmer environment. This ward had challenging and complex patients. We saw a health care assistant (HCA) escorting two patients from the ward who were in wheelchairs, to take them to the smoking area at night. One of these patients was verbally aggressive and challenging. The smoking area was unlit and was away from the hospital entrance. This situation deteriorated and help was needed to support the HCA. A second nurse from the ward eventually came to help the HCA. The trust told us the action the division would take would be to review and record a written risk assessment for accompanying patients outside, which assessed both staff and patient safety.
- The cardiac catheter laboratory used a World Health Organisation surgical safety checklist for all surgical procedures. We were unable to see any procedures but staff told us the records were not audited to ensure they were all fully completed. However, this did not provide assurance that safety checks were well implemented.
- We looked at ward staffing rotas and saw staffing levels were in line with the hospitals staffing measurement tool, with agency staff used when required to cover increased demand and vacancies. Staff told us they considered staffing levels to be safe with rare gaps in staff rotas when cover was attempted but not managed.
- Staffing levels were set across the hospital by the chief nurse and reviewed annually at a divisional level. Senior nurses used the safer care tool to record acuity and dependency. Scoring was recorded daily. The results were matched against the funded establishments and the staffing tool used from the Department of Health report, to ensure staffing was appropriate. Senior nursing staff met regularly to discuss staffing and skill mix.
- As a minimum, wards were staffed at a ratio of one nurse to every six patients during the day and one to eight at night. However, these ratios differed across the different wards within the hospital, based on standards specific to the patient group. On each ward we visited staffing levels met the dependency of patients and the acuity tool used, often using several bank and agency staff.
- In haematology an independent staffing review was carried out in 2014 by a nurse in a comparable service. The ward was staffed to match these recommendations.
- Duty matrons worked between 8am and 6pm and reviewed staffing and acuity. During the evening, the site team were responsible for this role. An escalation process was established for when extra staff were required.
- Seven whole-time equivalent nursing assistants were recruited to form an enhanced supervision team. This team provided one to one care for patients living with dementia, or to patients under a deprivation of liberty safeguard. These were patients who needed extra care and supervision and this provided extra assurance about their safety. Ward staff told us, when available; these staff were a great support.
- In July 2016 the hospital reported a vacancy rate of 9.3% in medicine for nursing. Vacancy rates for trained nurses varied within the medicine department. The stroke and respiratory wards had the highest rate of whole time vacancies with seven staff needed, as opposed to the higher care ward, which had two vacancies.

Nursing staffing

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- The hospital had a sickness rate of 5.7% in medicine for nursing staff. The NHS published data which showed the latest national average sickness rate for January to March 2016, was 4.37%.
- In July 2016 the hospital had a turnover rate of 14.1% in medicine for nursing staff and a bank and agency usage rate of 13.4% in medical care.
- Staffing levels varied depended on the specialty area. Staffing in the coronary care unit, the medical assessment unit and the respiratory higher care ward was planned using an acuity and dependency tool which reflected the higher level of patient complexity on these ward. Staffing was set at one trained nurse to two patients during the day and one trained nurse to two or three patients at night due to the high dependency nature of the units. Staff were expected to complete a red flag incident form for lower than expected staffing.
- Nurse staffing in the teenagers and young adults ward (a five bed inpatient ward for cancer patients) was staffed at a ratio of one nurse to every two patients in the day and one to every three patients at night. This took into account the paediatric patients staffing requirements and was reviewed daily by senior nurses. Staff recruitment and retention on this ward was a focus for divisional managers and matrons, as there had been difficulties in maintaining staff on this ward.
- Staff from medical wards could be called upon to work in the emergency department (ED). The staffing levels on medical wards could change depending on demand in ED. If there was an increase in patients in ED which exceeded three patients to one staff member, an escalation alert was noted in the bed capacity meeting. This led to the staffing levels on all wards being reviewed to establish which ward had capacity to loan a nurse to ED for a two hour block of time. The risks to ward patients were assessed and wards nominated to release staff. Should the ward then have a surge of demand, the staff member would have to be released back to the ward. Staff told us whilst they did not have any specific training for this role, they felt the ED department supported them. We received a varied response from staff to this staffing protocol, but there was a general acceptance of this practice. Some staff told us it gave them a wider knowledge of the hospital and awareness of the pressures in ED.
- For all staff working on the bank, agency or in a locum role, an orientation checklist was used to enable staff to familiarise themselves with the allocated work area. Staff were required to sign and date the form when completed to provide an audit trail of checks completed.
- Some wards and departments expressed concerns about staffing levels and skills. Nurses conveyed increasing concerns about the growing number of referrals into the haematology and oncology wards, where there was a higher number of more junior nursing staff. Whilst staffing levels matched planned levels, the unpredictability of workload and acuity of patients could vary. Fluctuations in demand occurred when patients required urgent access to care during the day or out of hours, accessed care through the acute haematology and oncology services. Urgent access and advice could be sought by telephone. Staff raised concerns this phone line was only covered by one band five nurse at night and weekends, but was manned by a nurse practitioner during the day. These concerns related to the risk of poor advice might be given and were listed on the risk register. We were told an incident occurred a few weeks prior to the inspection, where nurse staffing ratios on the oncology ward dropped below planned levels, as two acute oncology patients were admitted into this area of the ward. This left the main inpatient ward working on a ratio of one nurse to every twelve patients instead of one nurse to eight patients at night. This was escalated by staff, who confirmed staffing of the acute service was being looked at as part of operational planning for the future.
- On oncology and haematology wards senior nursing staff had encouraged staff to report incidents in relation to concerns about the staffing of the acute oncology service out of hours. Some senior nurses were concerned there had been a level of acceptance of incidents by staff, which may have led to staff being less likely to report incidents related to insufficient staffing levels. This was being reviewed by senior nursing staff.
- Staff we spoke with on cardiology wards C705 and C805 told us while staffing levels matched the planned establishment; it was difficult to leave the ward to attend training sessions. Some senior sisters on the ward often had to step in to help on wards, which meant they were no longer supernumerary and could not carry out management duties during those times.
- Staff on ward C705, a mixed cardiac surgery and cardiology ward, often cared for a small number of patients post cardiac surgery. Senior nursing staff said

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they felt able to challenge cardiac surgery management, if they felt skill mix and/or patient dependency compromised patient safety, and on occasions had done so. These wards worked together to ensure wards were staffed safely during sickness or staff absences.

- In the cardiac catheter laboratory the cardiac catheter laboratory manager was a committee member for a national cardiac intervention authority, which advised on staffing levels. Staffing levels in the department were set using these guidelines.
- Arrangements for handovers and shift changes kept patients safe. We observed staff handovers which were clear and concise. On the medical assessment unit, information was recorded about each patient on a handover sheet. These were passed on from night staff to day staff and then stored safely for any further reference.
- Health care assistants explained trained nurse vacancies were covered by bank and agency staff, but generally, healthcare assistant duties which needed to be filled were left vacant, causing increased pressure on other ward staff. Staff also told us about an inequity in rota planning, in that some staff had set shifts and other staff had to work around them. They felt this left some staff disadvantaged.

Medical staffing

- Arrangements for medical staffing kept patients safe. In June 2016, the proportion of consultant grade staff at the trust was higher than the England average. The proportion of junior (foundation year 1-2) staff working at the hospital was lower than the England average.
- Medical staff told us there were no problems accessing senior staff and consultants. Junior medical staff confirmed there was good middle grade doctor support and felt there were good opportunities for doctors including performing local audits, and care of the elderly education. They told us there were good relationships with other medical teams; an example given was of a particularly good relationship with the psychiatric and care of the elderly teams.
- Some medical staff we spoke with on cardiology wards felt junior doctors sometimes struggled to meet the demands of the busy ward, and cross covered different wards, which impacted upon time to access training. However, consultants were called upon to carry out ward rounds if necessary.

- On elderly care wards divisional managers confirmed there were no major concerns related to medical staffing. However they had experienced long term sickness with consultant and specialist registrar grades and had mitigated this by employing locum staff.
- In July 2016 the hospital reported a vacancy rate of 5.2% for medical staff, and a turnover rate in medical care of 4.8% for medical staff.
- In July 2016, the hospital reported a sickness rate of 0.7% for medical staff, and between September 2015 and August 2016 a bank and locum usage rate of 1.3%.
- Doctor induction was undertaken in scheduled blocks. Should doctors start work in between those blocks, they may work for a period of time without induction. We saw this had taken place for one doctor. This meant no fire training had taken place and should an incident occur may place both staff and patients at risk.
- There were consultants trained in general medicine available at all times. On the medical assessment unit there were three consultants. The acute medical consultant had responsibility for 20 patients, the gastroenterology consultant for six patients and the respiratory consultant for six respiratory patients, plus their ward specialty areas. There was a 'take' consultant who admitted patients referred from the emergency department and GPs. Their time on the medical assessment unit varied depending on activity. The on call consultant went home overnight, to be called in as needed. On the medical assessment unit there was also one ward registrar and one 'take' registrar (the registrar responsible for admitting patients) and a team of senior house officers (SHOs).
- The weekend medical team on the medical assessment unit included the 'take' consultant on duty, who admitted patients. Patients who needed review over the weekend were always highlighted to the registrar to be seen and, if needed, the on call consultant could be called in. Weekend cover was provided by the physician of the day between 8am and 9pm, two registrars (one 'take' and cover) and one discharge registrar. There were no formal ward rounds at the weekend, only those patients new to the ward were seen. Two ward cover SHOs and two ward cover junior doctors were available at weekends.
- There was a seven day consultant delivered service for endoscopy provided by nine consultant gastroenterologist physicians (mix of hepatologists, gastroenterologists and a medical endoscopist).

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- Consultants and junior staff started work with a handover at 8am and allocated patients to their specialties and doctors. From 5pm one registrar took charge of the medical cover, one registrar admitted patients and one SHO and one junior doctor covered the medical wards, with the exception of cardiology. One registrar was responsible for medical cover until 7pm. The junior doctor and SHOs were responsible for examining and taking patient histories for new patients. They told us they had good numbers of staff to meet the workload. At 9:30pm, there was a handover to the night staff which was run by the clinical site manager. The consultants usually remained on the medical assessment unit until 9pm and were then on call.

Major incident awareness and training

- The trust had major incident and business continuity plans. The trust-wide risk register acknowledged the risk to trust business and operations resulting from adverse weather conditions such as ice and snow, and the pressure put on services by large gathering of people based events. The trust had incident response and mass casualty plans in place. The local council informed the hospital about events planned for the year to enable the hospital management to plan staffing to support an increase in demand.
- Staff had an awareness of what action to take if a major incident took place and explained that, whilst they had not been part of any planned training, they were confident senior staff would provide guidance. The trust shared a presentation from August 2016 which highlighted winter preparations. This looked at escalation procedures to meet increased winter demand, which included learning from the previous year, and plans for times of increased demand.

Are medical care services effective?

Good



We rated effective as good because:

- Patients' care and treatment was planned in line with current evidence based guidance. Clinical care pathways were developed in accordance with national guidelines. Trust policies included reference to NICE guidance and other national strategies.
 - Patients received a comprehensive assessment of their needs and had their pain assessed regularly and managed promptly.
 - Patients' nutrition and hydration needs were assessed and actions put in place to ensure this was managed effectively.
 - The medical division achieved good patient outcomes and delivered effective care. A programme of local and national audits was used to monitor care and treatment. Some areas showed improvements, including the national stroke audit.
 - The learning needs of staff were identified and training put in place to meet those needs. Practice education facilitators were available to support staff and specialist nursing teams provided individual and group teaching for areas identified as needing extra support.
 - Patients received care from different teams who worked together to coordinate care. Multidisciplinary working was evident in all areas of the hospital. We observed board rounds taking place on wards, which demonstrated effective multi-disciplinary working. For some wards complex discharges were daily occurrences. There were links with GPs and community providers to ensure safe patient discharge.
 - Staff had access to information about their patients to deliver effective care and treatment. Staff worked cohesively to assess and plan ongoing care and treatment and to ensure safe discharge arrangements were made for patients.
 - Whilst care was provided seven days a week, ward rounds by medical staff did not take place every day. However, access to medical care was always available. Nurse specialists were available between five and seven days a week.
 - Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- However:
- There were no hospital-wide pain audits to assess if pain was managed effectively for patients who were able to express their level of pain.
 - Not all staff had received an appraisal in the last year. Without an appraisal, learning needs may not be identified and a plan put in place to support staff to develop their practice.

Medical care (including older people's care)

Evidence-based care and treatment

- The trusts policies and services were developed to reflect best practice and evidence-based guidelines. The hospital developed clinical care pathways in accordance with national guidelines. This ensured patients received the most effective treatments, in a timely way, from the most appropriate teams.
- Policies included reference to National Institute for Health and Care Excellence (NICE) guidance, for example the hospital policy for transfer of patients both internally and externally to other locations, referenced the NICE guidance Acutely Ill Patients in Hospital July 2007 and the south-west dementia partnership hospital standards in dementia care. This outlined clear roles, responsibilities and processes to ensure patients were safely and effectively moved between teams, both within and outside of the hospital. The National Dementia Strategy (2009) was used to develop the falls management policy, to ensure national policy and recommendations were implemented, avoidable falls and harm were reduced, and to promote a consistent approach to falls management across the hospital.
- The trust identified falls prevention as a priority area in 2016 and had instigated a programme in response, called 'Eyes on Legs'. The concept was devised by a ward sister and matron following a serious patient fall. They identified falls prevention had not previously been given sufficient priority by the ward's multi-disciplinary teams. Following this, the 'Eyes on Legs' campaign was rolled out across the hospital. The concept was to ensure all staff, regardless of their role, understood the message that falls prevention was everyone's responsibility.
- Staff from the teenagers and young adult ward used best practice guidelines to ensure patients achieved the most effective outcomes. Care delivered to young patients followed guidelines such as the NICE improving outcomes guidance for children and young people with cancer.
- Stroke pathways were in place to support patients to access the right services and effective treatment at the earliest point of admission, in line with NICE guidelines for the management of stroke and transient ischaemic attack. This meant specialist nurses and nursing staff were available at all times to undertake thrombolisation (the breakdown of a blood clot) and bring the patient from the emergency department to the ward.
- The hospital provided a medical ambulatory care unit which included a GP support unit to provide direct advice and support to primary care patients. The aim of the ambulatory care unit was to reduce unnecessary admissions and alleviate pressure on the emergency department and medical assessment unit. The ambulatory care unit lead nurse was keen to develop the service to provide a wider scope of service for patients.
- Patients were admitted to the medical assessment unit from the emergency department via ambulatory care or directly from GP referral. Those patients admitted directly from their GP were triaged on the medical assessment unit and directed to the correct admission or discharge pathway. The length of stay on the medical assessment unit was an average of between 24 and 48 hours. Some patients were held on the medical assessment unit if their safety was risk assessed, and it was considered the best place for them to remain until a ward bed was available.
- A range of specialist nurses provided specialist care and treatment to medical inpatients, education to healthcare professionals in the community and primary care, and to outpatients following their stay in hospital. For example, cardiology specialist nurses and outreach services such as the arrhythmia specialist nurse service, was implemented in line with the National Service Framework for coronary heart disease. The service helped to ensure patients were identified early when diagnosed in the community or in hospital, and by working to educate clinicians in primary care, to ensure patients were treated in line with relevant clinical guidelines.
- Enhanced supervision teams were established in the hospital to support wards and staff with patients with extra needs during the day. Plans were in place to extend the provision of this service at night. Their role included taking patients to the dementia café, activity clubs and supporting activities on the ward. They were allocated where a need was identified and were not counted as part of the ward staffing level. Usually three of these staff worked each day, this included night shifts. They carried a bleep to ensure they were used where needed.
- Trust protocols were available to staff via the intranet to support their practice. Staff told us they knew where to

Medical care (including older people's care)

access this information and were able to show us. These were also available on each ward in paper copy. Doctors told us there was good access to local guidelines including antibiotic guidelines.

- Staff said they received regular updates with new policies and guidelines. They were notified by email from senior staff within the trust, through team meetings, or during daily safety briefings on the wards. At team meetings staff told us clinical nurse specialists provided up to date advice and guidance about care, treatment, and changes to ways of working.

Pain relief

- Patients had their pain assessed regularly and managed promptly. In 20 records we saw patients had a pain score recorded and there was evidence of timely administration of pain relief when required. Pain assessments had been calculated correctly and medicines charts reflected action taken to address any pain levels found. Further monitoring recorded if those actions had been effective and any changes needed.
- We spoke with seven patients who confirmed their pain had been well managed and they were comfortable.
- Pain was also well managed on the oncology and haematology wards. We saw patients had access to a variety of pain medicines and eight patients across these wards told us their pain was well managed.
- Two pain scoring systems were used. A system was in place for patients who had the cognitive ability to tell staff about their pain. For those patients who did not have the cognitive ability, the Abbey pain score was used. This included a range of means to assess patients' pain levels for example facial expression. The national early warning score charts recorded which system of pain assessment had been used, and pain scores were included in the overall scoring system to identify patient deterioration.
- Pain audits were carried out across the medicine wards but these were focused on patients who were not able to say they were in pain. The use of the Abbey pain scale was audited by dementia leads each month and feedback provided to wards. The Abbey pain scale was used to assess pain levels for patients with cognitive impairment. The September 2016 dementia report showed a RAG (red, amber, green) rating of green in the Bristol Royal Infirmary during May 2016, July 2016 and August 2016. The average score showed staff assessed pain using the scale for 76% of patients during this time.

In specialised services, (the Bristol Heart Institute and the Bristol Haematology and Oncology Centre) the report showed audit scores for use of the Abbey Pain Scale were poor. Staff training sessions were implemented to ensure all staff were competent to use the scale. The report noted September 2016 data showed signs of improvement. There were no pain audits for patients who were able to verbally express their pain to establish if pain was also managed effectively for this patient group.

Nutrition and hydration

- The malnutrition universal screening tool (MUST) was used to calculate and record patients' nutritional risk. Patients' records showed these were correctly calculated and actions put in place to support each patient's hydration and nutrition. For example, when a patient had been assessed as at risk of dehydration, it was recorded on their prescription chart 'offer me a drink' with the amount and frequency, to ensure sufficient fluid was offered and recorded.
- The patients view on the hospital food was varied. Some patients felt the portion size and menu choice was sufficient. Others felt the portions were too small and did not meet their needs. We observed an evening meal being served and patients being asked if they wanted more or less food served. Patients told us they could access food late in the evening as staff would get them a sandwich. Staff told us they could ring the kitchen if needed for alternatives.
- Speech and language therapists were available between 8am and 5pm Monday to Friday to carry out a swallow assessment on all stroke patients. Should the assessment be needed out of those hours, nursing staff on the stroke ward were trained by the speech and language therapists to complete the assessments to prevent a delay in patients receiving the most appropriate and safe food and drink.

Patient outcomes

- The outcomes of patients' care were routinely collected and monitored to measure the effectiveness of care and treatment. The hospital took part in national audit programmes and also established local audits.
- The hospital took part in the quarterly Sentinel Stroke National Audit programme (SSNAP). This aimed to improve the quality of stroke care by auditing stroke services against evidence-based standards, and

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national and local benchmarks. On a scale of A-E, where A is best, the trust achieved a score of C in the audit (April 2016 to June 2016), which was an improvement of one grade over the score in the previous audits. All patient centred performance measures were the same or better when compared to the previous quarter, with seven of the 11 indicators showing improvement compared to the previous quarter. Team centred performance was similarly good with improvements seen for six of the 11 indicators and no indicators showing worse performance in the latest quarter.

- The hospital results in the 2014/15 heart failure audit were better than the England and Wales average for all of the four standards relating to in-hospital care. However, results were worse than the England and Wales average for three of the seven standards relating to discharge. Divisional managers informed us that in order to address this, additional nurses and consultants had now been employed.
- The hospital took part in the 2015 National Diabetes Inpatient Audit. They scored better than the England average in six areas and worse than the England average in 11 areas. The diabetes specialist nurses produced an end of year report for 2015/2016. This included progress with inpatient care and completed actions from the 2015 report. For example, one area which had not scored well was foot assessments, and the end of year report recorded progress with foot care pathways being employed on the wards.
- The trust took part in the 2013/14 Myocardial Ischaemia National Audit Project (MINAP) and scored better than the England average for all of the three metrics. This was the most recent MINAP audit, for which scores in 2013/14, showed an improvement over the previous year.
- There had been an improvement in the number of patients receiving antibiotics within one hour of arrival, for patients undergoing chemotherapy who presented with potential neutropenic sepsis. These were patients whose immune systems were compromised due to their treatment. Between July to November 2016 (5 months) 95% (19 out of 20) patients received antibiotics within one hour of presentation of symptoms, whereas between November 2013 and April 2014 the rate was 54%.
- The trust told us its primary percutaneous coronary intervention (PCI) programme offered extensive services to patients across the region. This is an urgent procedure carried out when patients present with

symptoms of a heart attack. Part of this PCI programme involved coronary intervention in patients suffering out of hospital cardiac arrests, who had been resuscitated. This involved cooperative working between cardiology and the general intensive care unit. Senior nursing staff informed us outcomes compared favourably with national and international benchmarking, but did not have access to data.

- The trust participated in the 2015 Lung Cancer Audit and the proportion of patients seen by a cancer nurse specialist was 95.3%, which was better than the audit minimum standard of 80%, and was an increase on the previous year's score of 76%.
- Outcomes for cancer patients on the teenage and young adults ward were measured through qualitative data, which looked at compliance with medicines and treatment. Compliance for teenagers and young adults undergoing cancer treatment is known to be challenging due to a wide range of age, psychological and social reasons specific to young people. Both qualitative and quantitative data showed demonstrable improvements to patient outcomes across a range of areas, of both the physical and psychological health of patients.
- Between March 2015 and February 2016, patients at the hospital had a higher than expected risk of readmission for elective gastroenterology and both elective and non-elective cardiology. Patients had a lower than expected risk for general medicine (elective and non-elective).
- The hospital provided a dedicated service for patients with heart conditions across Bristol and the South West. Divisional managers informed us the cardiology risk of re-admission was attributed to both the complexity of the patient group (which they deemed more complex than the national average), to the complexity of patients being referred from other centres across the region, in part, due to the strength of the specialist nursing team within the hospital.
- Local audits monitored a wide range of processes and outcomes such as: documentation, chest x-rays, requests for acute medical admissions at the hospital, elderly discharge summary standards, and unplanned admissions from home to hospital. These showed a good level of outcomes and compliance.

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- Falls management was audited regularly and actions produced as a result. The data showed whilst the number of falls per month varied and was seen to have increased in October 2016, the number of falls resulting in harm had fallen from March 2016 to October 2016.

Competent staff

- An appraisal was used to identify learning needs, and a plan put in place to support staff to develop their practice. A high level of staff had received an appraisal in the last year. In the year 2015/16, 82% of staff within the hospital had received an appraisal. However, the trust's target was 85%. Nursing staff appraisal levels were at 88%, medical staff 72%, and allied health professional appraisals at 86%.
- Staff told us they were provided with training to deliver effective care in their roles. There were a range of specialised staff across the hospital who worked closely with ward staff to meet their learning needs and improve competencies. Many staff had developed skills in a range of areas, such as dementia, falls, and infection prevention and control.
- Practice education facilitators were available to support staff and specialist nursing teams provided individual and group teaching for areas identified as needing extra support. For example, practice education facilitators worked seven days a week in haematology and oncology to support staff with learning and competency development. Nursing staff often took on link roles where they took the lead on their ward in some of these areas. They were provided with extra training and could support other nurses on their ward
- The diabetic specialist nurses, the respiratory specialist nurses and stroke specialist nurse all provided training. A number of cardiac specialist nurses including arrhythmia, heart failure and acute coronary syndrome provided outreach care to patients across the hospital and on cardiology wards. Other specialist nurses included tissue viability, learning difficulties, dementia and wound care.
- A number of staff we spoke with said they had been given opportunities to develop their skills and practice. They had accessed courses other than mandatory training, in order to enhance their skills or for personal development. Other staff felt funding was limited or gaining agreement for time off the ward was difficult to achieve. Some staff told us they had taken annual leave in order to access further training.
- Staff in the cardiac catheter laboratories received simulation training to practice resuscitation of patients, as patients receiving treatment and assessments there were generally at higher risk. The training also aimed to enhance communication skills within the team and incorporated human factors training.
- Staff on cardiology ward C705 (which provided care to a small number of cardiac surgery patients) were rotated onto the cardiac surgery ward for periods of six to nine months in order to ensure staff were competent to deliver effective patient care.
- The oncology and haematology service provided new staff with a supervision period lasting three months, along with a chemotherapy workbook to complete. New staff's competencies were then assessed to ensure their practice was safe. Registered nurses working on the oncology ward were provided with annual chemotherapy training together with a workbook to complete. There were additional competency training sessions, such as blood transfusion competencies. We reviewed a register of staff's chemotherapy competencies and could see all staff had attended a chemotherapy workshop, and there were good levels of compliance for staff who had attended a chemotherapy update in 2016.
- A quality improvement lead for foundation doctors provided support for doctors in training. Mentors who had been through the programme provided support to medical staff. Junior doctors were increasingly attending dementia cafés twice per month in order to improve their knowledge and skills to manage patients living with dementia.

Multidisciplinary working

- Effective multidisciplinary working was evident in all areas of the medical and specialist services we inspected. We observed board rounds taking place on wards which demonstrated multi-disciplinary working. This was an opportunity for a multidisciplinary team discussion about each patient's treatment, which was recorded in patients' notes and updated on the wards' white boards. The board rounds also included community services who were actively involved in discharge planning. For some wards the discharge of patients with multiple medical conditions and complex care needs were daily occurrences. There were good

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links with GPs and community providers to ensure safe patient discharge. In each discussion about the patient it was clear which consultant or team had overall responsibility for the patient's care.

- Multidisciplinary team meetings took place on all wards and we saw they were a forum for discussion and decision making of the patients care and treatment plans. On the stroke ward, in addition to the multidisciplinary meeting, there was also a stroke operations meeting to discuss any multidisciplinary concerns, or if patients were being cared for on an alternative ward.
- We observed a haematology weekly, multidisciplinary grand round, which was a paper based review of patients on the ward. We saw input from a wide range of healthcare professionals which included nursing and medical staff, and specialists from other services, including a consultant transplant specialist, palliative care and a clinical nurse specialist.
- On cardiology wards we noted allied health professional, social workers, pharmacy, dietetics, ward clerks and nursing assistants were often not present. On one cardiology ward we were informed social workers were available by phone. However, staff told us there had been a shortage of social workers and it was sometimes difficult to access them.
- Staff told us a three-times-a-day; multi-professional board rounds were conducted to progress patients' care and ensure safe and supported discharge. This included partnership working with Bristol Community Health rapid response team to facilitate early supported discharge for Bristol patients who were medically stable but required up to five days' further nursing/ occupational therapy/physiotherapy support to provide a safe discharge. The older persons' mental health specialist nurse was included in this board round.
- We reviewed patients' notes and saw evidence of multidisciplinary team working. For example, in one oncology patients' record we saw evidence of input from physiotherapists, dieticians, occupational therapy, speech and language, and medical and nursing input from other departments due to the patients' co-existing health conditions. We reviewed a further set of notes which showed multidisciplinary working between medical, nursing and allied health professional staff. A

further set of notes we looked at recorded input from a dietician, physiotherapist, occupational therapist, pain support services, stroke nurse and nursing and medical staff.

Seven-day services

- Whilst care was provided seven days a week, ward rounds by medical staff did not take place every day. Ward rounds took place each day Monday to Friday. All patients had a clinical assessment once admitted to the medical assessment unit by a consultant or registrar. This was undertaken within 12 hours.
- Medical staff could be accessed to ensure patients could be discharged at the weekend if needed. Medical cover was provided per specialty area between 8am and 5pm. After 5pm cover was provided by medical staff whose role it was to admit patients onto the medical and stroke wards.
- An on-call stroke physician was available through the South West Stroke Network rota after 5pm and before 8am and during weekends. This service covered a wide region which included Bristol, Gloucester, Swindon, Taunton, Yeovil and Salisbury.
- A consultant and registrar worked on cardiology wards at the weekend and were initially based in the coronary care unit to carry out a board round, then went to the acute medical unit or the emergency department to review patients due to be admitted to the hospital .
- Nurse specialists were available between five and seven days a week to provide specialist input to patient care.
- In 2014 a six day diabetes service was instigated which integrated inpatient and outpatient work. A new consultant had recently been appointed. Diabetic nurse specialists rotated working to include Saturdays. A telephone line was available for staff to leave messages and request a call back. Out of hours guidelines on the management of diabetic patients were available for all staff to access on the hospital's intranet. Out of hours generally meant after 5pm and before 8am and at weekends.
- The heart failure nursing outreach team carried out three rounds per week within the medicine division. The purpose of this was to increase access to care for patients with heart failure and to reduce the readmission rate.

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- Ward staff had access to mental health services for patients with physical and mental health needs. Telephone referrals could be made and the dementia lead nurse was available to help staff with the referral process.
- The specialist nurse stroke team were available seven days a week. Occupational and physiotherapists worked a six day week with the stroke service. For the medical wards, physiotherapists were available between 8am and 4:30pm Monday to Saturday, with Saturday being a reduced staffing level. Overnight there was access to an on call physiotherapist who could be called into the hospital. On a Sunday between 8:30am and 4:30pm the higher respiratory areas had access to a physiotherapist.
- The tissue viability nurses worked a five day week but had a support line where patients could leave messages and they would respond when on duty.
- The specialist respiratory service worked Monday to Friday, with a seven day service for patients with chronic obstructive pulmonary disease (COPD), provided in conjunction with the community health COPD team.
- Day case care and treatment was provided on the haematology day unit every day except for Saturdays.
- The medical ambulatory care unit was open from 8am to 8pm on Monday to Friday and admitted patients from the emergency department, GP referral and ambulance services, directly to the unit. They were supported by the medical staff from the emergency department.
- The general pharmacy closed at 6pm and an on call pharmacist was available until 8am when it reopened.

Access to information

- Staff had access to patient information to deliver effective care and treatment. Discharge letters were started well in advance of discharge and were completed by both the consultant and nursing staff. The letters were stored on the ward computer; they were comprehensive and accessible to staff to contribute to. This included pharmacy staff to record the take home medicines.
- When patients who needed specialist community support were discharged, the links were made with community services. For example, a patients needing diabetic follow up would have a GP discharge letter and a follow up referral to community diabetic services, depending on geographical location.
- When patients moved between teams and services within the hospital notes did not travel with the patient.

This meant it was not always easy to gain access to care records in a timely way. A variety of nursing and administrative staff told us they spent a lot of time chasing and collecting patient notes. Administrative staff mainly worked during daytime between 8am and 5pm, which meant patient records required by nursing staff at weekends had to be collected from other parts of the hospital. This meant staff temporarily leaving the ward and therefore reducing staffing levels during that time period. Administrative staff also had to leave positions unmanned whilst going to other buildings in the hospital to collect patients' notes.

- When a child's care transitioned from the children's hospital to the care of the teenager and young adult ward, information was shared between professionals who were involved in their care. Healthcare professionals and patients met with staff on the teenage and young adult unit to discuss and plan their care, during the transition period.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- In the 29 records we reviewed we observed consent had been obtained and recorded in each case and where consent was refused or not able to be provided this was clearly documented. We observed staff and saw they asked for consent before undertaking any actions.
- The trust undertook an audit of clinical consent in September 2016 with the aim of determining whether consent for treatment was being obtained according to trust policy. The results showed areas for improvement. A sample of 123 patients undergoing operations or procedures in January 2016 was used across five areas/ specialties within the trust. These areas included medicine, cardiology, oncology and haematology. There were 11 objectives and the results showed whilst medicine, cardiology and haematology scored well in many areas, there was room for improvement in some areas. These included 'the risks of the procedure/course of treatment will be recorded on the consent form'. Staff told us an action plan was being put into place to address the shortfalls.

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- The trust reported that Mental Capacity Act 2005 and Deprivation of Liberty Safeguard training was fully incorporated into safeguarding training undertaken by staff.
- We spoke with staff on wards including A400, C808 and the higher care respiratory ward, who described the local process for making a Deprivation of Liberty Safeguards application and were clear about their responsibility towards the patient.
- We reviewed 26 sets of notes and looked specifically at five sets of notes to review how do not attempt cardiopulmonary resuscitation (DNACPR) documentation was recorded. We saw the records included who the decision had been discussed with, the reason for the decision, their comments and any plans for review of the document. The document was signed and dated by the doctor and included their grade. No junior doctors had signed the forms seen.
- We observed staff took the time to interact with patients and those close to them in a respectful and considerate way. We heard of and saw many examples of staff delivering compassionate care and treating patients with kindness, dignity and respect.
- We spoke with 30 patients who were all positive about the care and compassionate treatment they had received from staff. We saw care provided to both patients, and their relatives and carers, which demonstrated staff, understood their patients' needs. They were always kind, thoughtful and polite. Patients made comments such as: "I don't know anywhere else in the world I would get this care and treatment"; "staff always have a smile"; "staff could not have been more helpful"; and "care has been first class".
- Patients on the oncology ward felt their care needs were met and spoke highly of the staff who were described as caring and kind. One patient said, "I receive what everyone deserves". Another patient receiving chemotherapy described the service they had received as "faultless".
- We supplied the hospital with comment cards several weeks prior to the inspection, so patients and those close to them could tell us about their experiences of care at the service. We received 80 comment cards and found the feedback about care they received was very positive. Comments included: "All staff (doctors, nurses and cleaning staff) were very kind and polite and did everything you needed"; "My needs have been responded to very well and quickly, from needs such as needing painkillers to needing a hair dryer!"; and "They [staff] have spent the relevant time listening to my needs and requirements and gone 'the extra mile'".
- We observed staff speaking to patients by bending down to their level, making eye contact and referring to them with preferred names and with references that demonstrated they had taken time to get to know the patient.
- The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients were happy with the service provided, or where improvements were needed. The Friends and Family Test response rate for medical care at the hospital was 50%, which was better than the England average of 25%. Between November 2015 and October 2016, over 90% of patients who had received care at the hospital would recommend the service to friends or family. However, on older people's wards A518

Are medical care services caring?

Good



We rated caring as good because:

- Feedback from patients and those close to them was positive. Patients were treated by kind, caring staff who were respectful and considerate.
- Patients' privacy and dignity was respected and staff sought permission before carrying out care and treatment.
- Staff often went out of their way to meet the emotional and physical needs of patients. It was clear they had taken the time to get to know and understand their patients.
- Patients and those close to them were treated as partners in their care and supported to make informed decisions about their care and treatment.
- Staff were without exception courteous and helpful.
- Patients' emotional and social needs were valued and this was demonstrated in the way staff cared for patients and in patient feedback.

Compassionate care

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and A528 less than 90% of patients in at least four out of the last six months would recommend the service. On older people's ward C808, only 73% of patients would recommend the service to friends and family in October 2016.

- We observed staff respected patients' confidentiality, privacy and dignity by ensuring toilet doors and curtains were always pulled closed and by knocking or seeking permission before entering. Voices were lowered when confidential or personal information was being discussed. Staff told us and patient feedback confirmed patients' dignity was respected. One patient who had been treated at the hospital for a number of years stated, "the staff have continued to deliver remarkable care, and an unfailing recognition of my dignity and shown sincere respect. I consider myself exceedingly fortunate to experience the NHS care and treatment. This is true of consultants, registrars as well as the nurses."
- Staff told us they understood and respected patients' personal, cultural, social and religious needs and took these into account. We saw care records recorded any personal, cultural or religious preferences to ensure staff could respect them.
- The cancer patient experience survey had rated the trust lower than the national average. Divisional managers told us the trust had engaged in working with a buddy hospital in order to learn from them and improve the cancer patient experience.
- When patients experienced physical pain, discomfort or emotional distress, we saw staff responded with kindness and compassion in a timely way. Patients said their needs were responded to in time and with good care.
- We heard of examples where staff often went out of their way to care for patients in the hospital to meet both their physical and emotional needs. Staff in one area of the hospital tracked down a patient's relatives and facilitated a reunion. The patient expressed how happy this had made them. The same nurse held their hand when the patient later passed away. Staff on the oncology ward told us staff of all grades had gone out of their way to care for patients, often carrying out errands and tasks for the patient in their own time. We heard particular examples of this in relation to terminally ill patients.
- We saw numerous instances when hospital staff in the corridors were stopped by patients and relatives to ask

for directions or assistance. Staff were without exception, courteous and helpful. We were particularly impressed by porters and cleaning staff who were extremely helpful to relatives and patients. We saw one of these staff escort two relatives to where they needed to be. They did this in a friendly and inclusive manner that was considerate of their walking pace, which put them at ease.

Understanding and involvement of patients and those close to them

- Staff showed an encouraging, supportive and sensitive attitude to patients and those close to them. Patients told us they felt involved in the decisions about their care, and relatives told us they were kept informed and updated with any changes to their relatives care.
- The family of a patient in the hospital commented about their experience of bringing a relative to the hospital for treatment and stated, "From the beginning she (the patient) was treated with total dignity and respect as were we as relatives. All the staff without exception have been friendly, extremely helpful and have kept us informed of what is going on at all times. It is such a pleasure to deal with such caring wonderful people. This hospital is first class."
- Staff in the teenagers and young adults ward worked closely with patients, their carers, families and social network, to provide ongoing support to patients and those close to them.
- We observed staff worked collaboratively with patients and carers and encouraged their involvement. For example, nursing staff on the oncology and haematology wards described their awareness of how a diagnosis affected those close to the patient and how important it was to support the friends and families.
- Relatives told us visiting times were flexible to meet the needs of family members and their working lives. We visited in the evening and saw some relatives were able to visit later. We also overheard a telephone conversation where staff were helpful in enabling a relative from further afield to visit outside of normal visiting times.

Emotional support

- A hospital chaplain visited the wards once or twice a week to provide emotional support to patients and their relatives.

Medical care (including older people's care)

- We spoke with a patient and family who told us how the staff had tried to ensure they were treated by the same medical team as their admission several years earlier, in order to provide consistency of care.
- Clinical nurse specialists were available across the hospital. We saw the specialist staff working on all wards and records confirmed their ongoing input in patients' care, which included emotional support for their clinical specialties. For example, a tumour clinical nurse specialist provided emotional support and advice to patients and families.
- In the oncology and haematology department patients and families had access to a range of services to help them to manage the emotional impact of their care and treatment. The cancer information and support centre sign posted patients to the support they could access both within and outside of the hospital, which included from volunteers and charities. Staff told us they would refer patients here for further emotional support where appropriate. Psychological and palliative care services were available for patients to access.
- Staff empowered patients to manage their own health, care and wellbeing to maximise their independence. Feedback from patients and observations of care, showed how staff taught patients to manage their care in their own homes, for activities such as dressing and bathing themselves, or in changing wound dressings.
- Staff in the cardiac catheter laboratories worked closely with patients and carers to educate them about their diagnosis. They described to us how they used images of cardiac vessels displayed during procedures, to inform them about their condition, where appropriate.
- Staff in the teenagers and young adults' area clearly articulated their understanding of the needs of young people using the service, who were faced with cancer at a critical stage in their life. This included patients' physical, emotional, educational, social, sexual and employment development. A range of initiatives were in place, to support patients' varying needs. Support included, counselling and psychological care, along with a range of social activities both in and off the ward, such as cake baking, arts and crafts, and music events. Door labels were used so patients could make clear if they wanted to be left to sleep until their chosen time. This helped patients to regain an element of control over their disease and feel empowered to make decisions about their care.

Are medical care services responsive?

Good



We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of local patients. The hospital offered choice and flexibility to patients and provided continuity of care. New clinics, services and virtual facilities were implemented, to ensure services met patients' needs.
- The service delivered was creative to ensure patient flow through the hospital was maintained and was responsive to the ever-changing demand. There was a constant oversight by senior staff, of how different departments were managing flow, to ensure staff across all areas of the hospital prioritised patient safety, whilst maintaining the flow of patients through the hospital.
- The flow of patients through the medical division was monitored and actions taken to minimise the numbers of patients being cared for on wards other than those related to their medical condition or specialty. These patients were known as medical outliers. The hospital ensured outlying patients received the care and input from nursing and medical staff, relevant to their medical condition or specialty.
- Transferring patients out of hours was avoided. Transfers, whenever possible, took place between 8am and 8pm to avoid disruption to patients and maintain safe staffing levels. Discharge delays, transfers and bed moves were all monitored to ensure they did not impact negatively on patients' care and treatment.
- Access to care was managed to take account of people's specific care needs, including those with urgent care needs.
- Complaints were handled in accordance with trust policy and improvements were made in response to complaints.

However:

- Processes to ensure patients who were medically fit to leave the hospital were not always effective. However, in the majority of cases, reasons for discharge delays were not attributable to the hospital.

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- Referral to treatment times for different specialties including within the medicine division were not all within the national standard. The referral to treatment time for cardiology patients was worse than the England average.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to ensure flexibility and choice so patients received care in an appropriate setting. Ambulatory care pathways were in place to enable patients to avoid admission to the hospital where appropriate. A scoring system was used to guide staff when assessing patients, where the higher the score meant patients were more suitable and appropriate to be sent home. The unit used a three track triage process to categorise patients for a, same day admission, future admission, or 'bring back for a clinic', category. The ambulatory care clinic had seen an increase in gastroenterology patients which was now 50% of their work.
- Endoscopy services were run through theatres. To cope with increasing levels of demand, four gastroenterology beds were allocated on the respiratory higher care bay. These beds were under the care of the gastroenterology consultant and endoscopies were undertaken with recovery on that ward. A higher care bed was maintained to provide access to care for these emergency patients. Staff on the respiratory ward told us they would sometimes assist with the endoscopies, as they had received training to do so.
- Services provided were reflective of the needs of the local population, ensured choice and continuity of care. The trust contracted with a third party company to provide a virtual ward to support patients to receive treatment at home, whilst still being under the supervision of the hospital. This service managed up to 19 patients in their own homes. Treatments included intravenous antibiotics and patients were visited by the staff to provide care and support where appropriate. The service was implemented to reduce avoidable admissions. Should the patient deteriorate, they were transferred directly to the medical assessment unit, and did not have to wait to be seen in the emergency department.
- The hospital implemented a nurse-led transient ischaemic attack (stroke) clinic on the stroke ward. This service enabled patients to be treated without

admission. Should an admission to the hospital be considered, they could be seen by a doctor at the clinic. The nurse saw up to nine patients at each weekday clinic. The clinic did not operate during weekends.

- Staff told us about the dementia café which was held twice a month, and both patients and their carers were encouraged to attend. The café provided access to games and memory tools but also offered a social environment for patients and carers to meet and share experiences. We saw on ward C808 activities were provided to support patients living with dementia. Activities and entertainment were also provided on the ward.
- Information about the needs of teenagers and young adults were collected during project work and through ongoing feedback from patients and those close to them. It was used to inform the design and redevelopment of the teenage and young adult area, which underwent refurbishment in 2014. Subsequent project work and ongoing feedback enabled the service to continue to develop, reflecting the needs of the teenagers and young people using the service.

Access and flow

- The service delivered was flexible and creative to ensure flow was maintained. Since the inspection in 2014, divisional managers had focussed on improving patient flow and discharge, by working more closely with community based care to access beds within the community, and through initiatives to treat patients at home where possible using a virtual ward or the SAFER patient flow bundles. These were guidelines the hospital implemented which ensured patients were reviewed by a consultant earlier in the day, with a focus on discharge and overcoming any barriers to this, early on in the patients' stay.
- The trust anticipated receiving around 45 medical admissions each day. This level could vary and on the first day of our inspection there were 52 medical admissions. We saw that whilst this day and the following day were very busy, flow was maintained by a process of evaluation and prioritisation. There was a constant oversight of how other departments were managing flow and looking at the hospital in a wider context, to ensure staff across all areas of the hospital prioritised patient safety, whilst maintaining the flow of patients through the hospital.

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- The trust had an escalation plan which was last reviewed in November 2015. This plan was drawn up to ensure any patient coming into the trust, could access safe care, in a timely way. The objective of the escalation plan was to maintain the hospital at 'green' escalation status (low levels of pressure), with no obstructions to patient flow. The actions outlined at 'amber', were designed to return the situation to 'green' and prevent deterioration to 'red' escalation at which point patient flow would be compromised. We observed the escalation plan being used with the trust being in 'red' status during the inspection. We observed the plan being followed and the status fluctuating, as staff implemented the escalation process.
- There were a series of meetings throughout the day to identify issues with capacity and flow, escalation, discharge planning and breaches. These meetings included staffing levels to ensure sufficient staff with the right skills were in place to meet ward demand. Should flow become a problem, extra meetings were put in place to keep a close eye on any changes required to manage patient flow.
- An escalation ward was available should an increased bed capacity be urgently needed. Managers had not requested for this ward to be opened during the inspection, as it was not considered to be needed, but we observed the ward not be in a state of preparedness should it be needed urgently. We discussed this with senior staff who addressed this.
- The medical assessment unit had a treatment room, which was used for patients when additional beds were needed. The room was often temporarily used in this way but was not entirely suitable. No toilet facilities were available and so only patients who were mobile could use this. The use of this room also prevented the ward using the treatment room for its designated purpose. The regularity of its use was not recorded; however staff told us it was used regularly when there was increased patient demand.
- Data provided showed in the 12 months prior to our inspection, medical bed occupancy ran at 98%. When occupancy runs above 85% there is an increased risk to patients. On occasions where ward occupancy levels were high, patients were admitted to wards which were not identified for their medical condition/specialty. These patients were known as medical outliers. The hospital ensured outlying patients received the care and input from nursing and medical staff. This ensured patients' care was not negatively affected by being on an outlying ward.
- From July 2016 to October 2016 there had been 105 days when patients were not in the correct department in oncology, 284 in cardiac services and 725 in medicine. Divisional managers told us there was a reduction in the number of medical outliers compared to the previous year, and attributed part of this to the changes that were made to its bed base model. For example, ward A605 was changed from a surgical ward to become a medical ward.
- On day one of our inspection there were 13 outlying patients. After a busy night of admissions, on day two this had increased to 21 outlying patients. The outlying patients were recorded on a board in the bed site office and on the electronic information system. We visited five outlying patients on their wards and reviewed their records. We saw they had been visited each day by a medical doctor, with the exception of the weekends, when a weekend plan was recorded. Staff explained the system in place to contact the appropriate medical doctor for each patient. They told us the system worked effectively, and records confirmed in one instance when staff were concerned about a patient's deteriorating condition, they had called the medical doctor who had attended promptly. Divisional managers told us if oncology or haematology patients did have to be admitted on outlying wards, they were risk assessed so only clinically stable patients would be selected.
- The hospital and ward ensured outlying patients received care and input from suitably skilled nursing and medical staff. For example, on cardiology wards, senior nursing staff said staffing, skill mix and patient acuity would be considered before taking on any outlying patients. They said they were able to challenge any decisions to ensure wards were safe, and gave examples of two occasions where they had not agreed to accept outlying patients onto the ward.
- Between April 2015 and March 2016 the average length of stay for medical elective patients at the hospital was three days, which was lower than the England average of 3.9 days. For medical non-elective patients, the

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average length of stay was 8.2 days, which was worse than the England average of 6.6 days. All delays were monitored and audited to look for any reasons or trends the trust could use for improvement.

- Discharge delays, transfers and bed moves were all monitored to ensure they did not negatively impact on patients. The trust aimed to discharge or transfer patients earlier in the day and so started discharge planning as soon as possible. Of the patients discharged, 29% left the hospital between 7am and 12pm.
- The processes in place to ensure discharge from hospital for those patients medically fit to leave were not always effective. However, in the majority of cases the reasons for the delays were not attributable to the hospital. Some patients experienced a delay in discharge as they were waiting for services to be put in place to support them at home or in the community; these services were outside of the hospital's control.
- The reasons for delayed discharges were audited by the trust. In the year from August 2015 to August 2016 there were between 33 and 60 patients per day awaiting discharge each month. The reasons for delay included the agreement of funding for care in the community, patients waiting residential and nursing home placement, patients awaiting non acute beds in local hospitals, and access to homecare packages. There were also delays caused by the process of families viewing and selecting residential and nursing homes, as well as patients awaiting access to assessment and re-ablement services. Of the delays recorded by the trust and provided to us, we could only identify seven which were a result of the hospital's processes. These were due to delays in decisions being made by multi-disciplinary care.
- At the time of our inspection there were delays in transfers of care or discharge for 70 patients who were deemed medically fit for discharge. The hospital provided a discharge ward where 18 beds were occupied by patients who were ready to be discharged, but were awaiting packages of care. There were a further 11 patients waiting on other wards for a bed on this discharge ward. Of these 18 patients on the ward, 12 were waiting for nursing/residential home placements, six were awaiting packages of care, and three were also waiting funding. None were delayed as a result of the hospital's processes.
- The remaining 41 patients fit for discharge were located across the hospital. Their location and status for discharge was monitored by the bed management team, to ensure the discharge process remained ongoing.
- The trust continually monitored patient discharge data to highlight any ways that discharge and transfer could be made more efficient. Work to reduce delayed discharges continued as part of the emergency access community wide resilience plan.
- The medical division used the hospital discharge lounge to support earlier discharge from the wards and appeared well used. There were between 25 and 30 patients per day who were discharged from the hospital through the discharge lounge, with an average length of stay in the lounge of around three hours. The lounge was open from Monday to Friday from 8am to 8pm and had a set of criteria for its use. There was no facility for patients to lie down if needed. If there was any deterioration in a patients' condition, the patient would be returned to the ward. Discharge lounge staff could decline a patient transfer if they felt the discharge lounge was not a suitable environment for that patient. The lounge was staffed by a trained nurse and a health care assistant. They were also supported by volunteer staff. Hot meals and sandwiches were available throughout the day.
- Transferring patients out of hours was avoided. Transfers, whenever possible, took place between 8am and 8pm to avoid disruption to patients and maintain safe staffing levels. Although the trust did not advocate the transfer of patients between wards out of hours, there were occasions when this was unavoidable, and patient transfers and discharges at night did take place. If an out of hours transfer was required, a criterion must have been met. Staff had a duty to report out of hours transfers of patients with a learning disability or dementia.
- There were systems in place to monitor the number of times a patient had to move ward, with actions implemented to try to reduce the number of times patients were moved. Between August 2015 and July 2016, 31% of patients did not move wards during their admission, and 69% moved once or more. The highest amount of bed moves at night within the medical division was on ward A400, the older person's assessment unit, which had between 14 and 28 moves per month over the last six months. Staff told us this was

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because it was an assessment unit and not intended for inpatient stay. The bed management team monitored the number of moves and considered this when making decisions to move patients. The bed management team told us they tried wherever possible, to avoid unnecessary moves.

- The trust told us there had been no mixed sex breaches on any wards within the trust. Staff told us mixed sex breaches did occur, but had agreed timescales with the local commissioners to ensure when they occurred, they were afforded time to reorganise and move patients.
- Not all patients had timely access to initial assessment, diagnosis or urgent treatment due to increasing demand on the service, particularly in cardiology. Rheumatology exceeded the national standard. Thoracic medicine, geriatric medicine and gastroenterology almost met the national standard. Specialties such as dermatology, cardiology and general medicine did not always meet the national standard. This meant that patients were not always seen within the 18 week referral to treatment standards.
- The referral to treatment time for cardiology patients was significantly worse than the national standard. Divisional managers told us cardiology referral to treatment times were improving. The percentage of cardiology patients receiving treatment within 18 weeks between November 2015 and October 2016 was 61.9%. This was below the England average of 85.3%. Delays were attributed to a shortage of cardiology physiologists and to increasing demand for the service at a local and regional level, in particular for cardiac ablation services. Divisional managers reported difficulties with access to services across the south-west and with service commissioning. We were told the 92% standard would be met within the two months following our inspection, based on the trend at the time.
- The medical division had plans in place to minimise the time people had to wait for their treatment or care. For example, in dermatology as a result of rising demand in the service a system wide strategy was in development. This was being overseen by NHS Improvement, clinical commissioning groups and the trust. Another example is in haematology where plans were in place to increase the number of beds by the beginning of 2017. Although performing better than the England average, plans were in place to increase capacity to further mitigate the risks associated with demand.
- In order to manage capacity, a fourth catheter laboratory opened in July 2016, with plans being discussed for a fifth catheter laboratory. The service extended its working day to offer increased sessions. Due to recruitment issues with cardiac physiologists there had been a focus on the development of existing staff in order to manage capacity internally.
- In the cardiac catheter laboratories, a project was underway to ensure all sessions were "starting on time". This ensured four extra patients per day received their intervention and as such had increased capacity. Due to the increasing levels of demand, and issues with the recruitment of cardiac physiologists, risks flagged by senior staff from the cardiac catheter laboratory related to capacity within the service. The hospital had focused on recruitment and on ways in which the department could increase capacity, both in recent times and in the future to ensure its service provision met the demand. Senior staff within the department and at a divisional level confirmed plans were being discussed to expand the service further, to meet current and predicted demand. Whilst some referral to treatment standards currently exceeded the 18 week wait, we were informed urgent patients were prioritised and were being seen within days.
- Access to care was managed to take account of any specific and urgent care needs. For example, the hospital was part of a city-wide cancer performance improvement plan and had worked on access to services. A pathway mapping exercise was completed whereby any breaches in standards were examined, and actions taken to implement learning.
- The hospital provided an outreach service for acute heart failure patients. This meant patients with heart failure, who were being treated for other conditions on medical wards, received care and treatment for this condition. Staff were focused on meeting their care needs and ensured patients received the input required from allied health professionals, such as occupational or physiotherapists, dieticians and social care input.

Meeting people's individual needs

- The hospital took account of patients' specific needs. Translation services were available on each ward with the use of a language telephone service and a translator could be requested. Interpreters could be booked to visit the ward. Staff confirmed this had happened and had been successful. Family members were only used

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for translation if the issue was non-medical. We saw one patient for whom English was not their first language. The patient had a long treatment plan and had received numerous interpreters at the hospital, to support in understanding their care plan. The patient was happy with their care and treatment.

- All of the wards had accessible information leaflets in different languages for patients to access regarding a variety of medical conditions. We saw signage in multiple languages and large print to ensure patients could access the information they needed.
- The needs of different patients were considered when planning and delivering services and work had taken place to deliver a dementia considered service. A visual identification system was used for patients with a cognitive impairment - a forget me not flower. This highlighted the need for staff to adapt their communication strategies and approaches to providing care. The "All About Me" document was given to patients and/or their carer to complete, to help staff provide as individualised care as possible.
- There was a dementia strategy implementation group who formulated an action plan to develop the dementia provision. The trust had a named consultant geriatrician who was the lead for dementia and delirium. There was a lead dementia practitioner in post together with a dementia nurse practitioner and support worker. The team was notified of admissions via the clinical alert system. Referrals were made by agencies: for example, the dementia well-being service, safeguarding team and the later life mental health team.
- The monthly audit for caring for patients with a cognitive impairment care plan was introduced in 2014. The medicine division was consistently compliant: the numbers of patients with this care plan were significantly higher than the other divisions, which demonstrated the medicine division understood the importance of delivering care for these patients.
- The clinical alert system was used for patients with a learning disability, Parkinson's disease and known carers. This meant teams and services were alerted when these patients were admitted to, or attended the hospital. This ensured the hospital provided timely access to additional specialist support, review and services.
- Individual care needs and adjustments were put in place. When individuals with learning disabilities were referred to the learning disabilities team by carers or

external providers (local authority), the learning disability team was able to support pre-planned admissions and make reasonable adjustments according to identified needs.

- For patients who were visually impaired individual care needs and adjustments were put in place which included adjusted cutlery, non-slip plates, assistance with meal times and assistance with menu selection.
- It was common for patients who were hard of hearing to be put in a side room upon request, so they could have their radio/TV on at a raised volume without upsetting the other patients. The trust has been signed up to the 'Deaf Health charter' for the previous 18 years. This charter details best practice standards which were used to guide the practice standards and work of the link nurses. We did not see this in practice but staff were clear that support and assistance was available for patients who were hard of hearing.
- A new lounge was provided for patients undergoing treatment in the cardiac catheter laboratories. Staff felt this made patients more comfortable and helped patients living with dementia to remain calm and comfortable. There was seating, a fridge, a drinks machine, a television, books and games available.
- For patients with bariatric needs equipment was available on request. The medical assessment unit had bariatric equipment and could request a hoist. Staff on the elderly care ward confirmed that should specific hoist and stand aid equipment be needed, this was accessed through the equipment store and physiotherapy teams.
- Most areas of the hospital were accessible for patients with limited mobility or who used mobility aids. Disabled toilets were available for patients and visitors. Wards had access to single rooms which staff told us they moved patients to where appropriate, to ensure they were able to meet patients' specific needs.
- For those patients who were homeless and rough sleeping, if staff considered them to be at risk due to their health on discharge, staff would contact the social worker on call or contact the local hostel to ensure patient safety.
- Patients' spiritual and religious needs were provided for. Staff knew how to contact the appropriate chaplaincy lead. There was a multi faith prayer room available in the hospital. The chapel in the hospital building was closed in July 2016 for ongoing refurbishment work, but an alternative room was provided.

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- The trust appointed a wellbeing coordinator in the teenager and young adult ward and developed the concept of a “wellbeing pathway”. This integrated a holistic needs assessment at diagnosis and during treatment, with an end of treatment reassessment and ongoing support during the “living with and beyond cancer” phase of care. This approach meant young people with cancer had their complex, physical and emotional needs individually assessed and support and resources were offered for longer term self-management.
- The cancer support service provided a friendly, confidential service where patients affected by cancer could talk to someone in person or on the telephone. Other services and workshops available provided practical guidance with tying headscarves, hats and wigs, as well as make up workshops and massage or creative writing.
- Some patients told us sometimes they had little to entertain themselves with, as not all patients had access to TV and Wi-Fi. This varied from ward to ward. Some patients had access to free television and radio systems, and books which included books in large print. A day room was available on wards with access to water. These rooms were also used for private conversations.
- Patients told us when they used the call bell staff came quickly. The hospital monitored patient satisfaction which included monitoring call bell response times. We observed when call bells were rang, staff responded promptly.

Learning from complaints and concerns

- Complaints were handled in accordance with trust policy. Between February 2016 and August 2016 there were 96 complaints about medical care provision at the hospital. This was by division, the highest amount of complaints across all divisions in the hospital. The hospital took an average of 24.7 days to investigate and close these complaints. Timescales for resolution of complaints was 30 working days according to the hospitals policy, and were confirmed as part of individual local resolution plans. We reviewed the complaints information and saw there was a range of themes which included attitude and communication by staff, cancelled appointments and delays for treatment. For each complaint there was a description and action, with a resulting outcome recorded.
- Patients told us they felt comfortable to raise a complaint with staff, or would contact the hospital following discharge.
- Staff told us that on receipt of any complaint, they would endeavour to resolve it on the ward, but would also provide patients with information on how to formalise their complaint.
- Notice boards on wards displayed examples of how they had responded to patient complaints or concerns. For example, on the coronary care unit, staff took action to reduce the level of machinery noise on the ward in response to a complaint.

Are medical care services well-led?

Good



We rated well-led as good because:

- There was a clear, overarching statement of vision and values for the medicine service, which was driven by safety and quality. The medicine division and specialised services divisions' vision and strategies were developed within the context of this. Staff understood the vision and strategy and their role in delivering it. They were proud to work for the hospital and patient focused. Staff demonstrated a kind culture, both to patients and relatives, and to each other.
- Governance structures were complex to follow. However, the board and other levels of governance within the hospital functioned effectively and interacted well. Staff assured us risk was escalated when needed and the information communicated to the hospital board flowed well. Processes were in place to monitor, address and manage current and future risk. Performance issues and concerns were escalated to the relevant committees and board.
- Leaders understood the challenges to good quality care within and outside the organisation, and there were collaborative relationships with stakeholders.
- Staff felt leadership was good and divisional lead staff were accessible. Staff told us they felt supported and heard, and there was a collective culture of openness to drive quality and improvement. Leaders and staff demonstrated the participation and involvement of patients who used the service was important to them.

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- The hospital had forged strong links and worked closely with the voluntary sector. There were over 400 volunteers assisting at the hospital.
- Leaders demonstrated a drive for continuous learning and improvement through the ongoing evaluation and monitoring of the service and by delivering projects and innovative developments aligned to this.

However:

- The management of risk did not protect staff on the hepatology ward. Senior staff were aware of risks for patients and staff when accompanying patients off the ward at night who wanted to smoke, but had not put the required processes in place to mitigate the risk and ensure safety.
- The management and governance of current performance of staff mandatory training did not ensure all staff were fully training. For medical staff, this included fire, safeguarding and resuscitation training.
- The division had recognised a risk in the acute oncology service at night, concerning both staffing levels and a lack of suitably skilled triage staff. However, sufficient action was required to minimise the risk to patients in both the service provision and staffing provision.

Vision and strategy for this service

- The trust had developed a quality strategy for 2016-2020 for the overarching medical service, which incorporated medicine and the specialised services divisions. Specialised services included cardiology at the Bristol Heart Institute (BHI), and oncology and haematology at the Bristol Haematology and Oncology Centre (BHOC). Strategic development focused on working collaboratively with stakeholders to deliver of high quality local, regional and tertiary services, to develop and expand specialist services, and to deliver excellent care with compassion.
- The purpose of the quality strategy was to articulate the trust ambitions for quality in a way that was meaningful. It served as a statement of intent that patients, carers, staff, commissioners and other stakeholders could use and to hold the trust board to account, for the delivery of high quality services. Whilst specialised services had their own strategies and key priorities, they were set in the context of the overall medical service strategy. Divisional managers reported there was consistency between the clinical divisions within the medical service, and the trust's strategy.

- Divisional managers articulated the haematology and oncology strategy was focused on the capacity and capability to cope with increasing demand, through the number of beds, staffing and skill mix. They aimed to expand the research element through clinical trials to ensure access and use of the best medicines and treatments, being a regional centre. Additionally, the vision was to improve patient experience through the refurbishment of the oncology ward environment and by working with a buddy hospital.
- The vision for cardiology services was to expand the service, offer new innovative treatments and technology and to play a constructive role in cardiology service development and sustainability within the region.
- Staff we spoke with across all areas of the hospital demonstrated their understanding of the trust's vision and strategy. Staff were aware of ways in which the service aimed to achieve the vision, drive quality, safety and patient experience.
- The organisation proactively engaged and involved staff in the strategic development of the service. Staff told us their views were considered and staff embraced change in order to improve patient care.

Governance, risk management and quality measurement

- Governance structures were complex to follow. However, the board and other levels of governance within the medicine and specialised services divisions functioned effectively and interacted well.
- The divisional management of both the medicine and specialised services divisions varied in their construction and had different governance pathways. Within medicine services, both the medicine and specialised services divisions reported to a divisional level board. This board reported to the divisional directors, clinical chair and to the senior leadership team at trust board level. Whilst it was difficult to understand how the services were aligned, staff did not raise concerns in relation to this. However, we were told proposals for changes to this were made to the board in the month prior to the inspection, which had not at that time been approved.
- Governance frameworks and management systems were reviewed and evaluated regularly. The trust commissioned an independent review of governance which included the medicine division. This report recognised governance for elective and non-elective

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care was difficult to follow. During the inspection, we recognised because there were several specialties, all with their own governance arrangements, it was complex and sometimes difficult to review as a whole. However, we found there were effective governance frameworks in place overall, which supported the delivery of the strategy and good quality care.

Information travelled from ward to divisional and trust boards, and back again. Risks were identified and plans put in place to address those risks. Staff felt confident to raise risks and received learning from wider trust issues.

- The medicine division floor to board tool was put in place to enable front line ward and departmental issues to be raised. Ward sisters/managers reported the quality, safety and experience of their patients to the divisional board, and upwards to the trust board. The tool was laid out using the CQC Fundamental Standards and replaced the previous outcome based framework used.
- There were comprehensive assurance systems, which measured quality, effectiveness, safety and risk. The trust undertook a patient safety and clinical risk report quarterly. This identified issues arising from patient safety incidents reported during the quarter, and provided an analysis by harm, risk and cause. The quarter's data was placed in context with previous quarters to identify trends. Divisional managers told us they reviewed quality and safety performance regularly and reviewed and set priorities for their respective services each year.
- Governance arrangements supported quality and safety across all areas of the division. For example, specialised services provided by the Bristol Haematology and Oncology Centre and the Bristol Heart Institute each had levels of clinical and information governance that flowed across the two sites. Matrons across all areas of the hospital met monthly and shared ideas across the divisions. Initiatives were instigated and rolled out hospital wide, such as mini teaching sessions for staff with a focus on improving quality of care and patient safety. There was a focus on nutrition in the month of September 2016 and on cognitive impairment during October 2016.
- There were separate, specialised services and medicine divisional, clinical governance and risk management meetings which fed into the divisional and trust boards. We saw risks were reviewed monthly, and included investigations of serious incidents and root cause investigations. This meant any risks of concern could be flagged to the divisional and trust board and addressed at monthly management meetings and shared across the hospital.
- The risk registers for the hospital were extensive and it was clear to follow how risks were being reviewed and managed. Staff took action to improve performance as a result, and risks within the hospital matched those highlighted on the division's risk registers. For example, the trust wide risk register noted a risk of information governance breaches, leading to a breach in patient confidentiality. There was a risk staff who had not undertaken information governance electronic learning training may not be fully aware of their responsibilities under the Data Protection Act. This was rated as a moderate risk and actions were put in place to address this, such as distributing messages to raise awareness of training through payslips, and to monitor the monthly uptake of e-learning to improve compliance rates.
- Through effective governance review processes, staff felt the board executives had an improved understanding of falls, and had both questioned data and presented challenges. There was an executive lead for falls in place. A focus on falls management was developed with a falls lead and falls champions in all areas of the hospital. Staff received further education and training in falls to ensure skills were orientated to this and awareness increased.
- Staff in the cardiac catheter laboratory used a World Health Organisation (WHO) surgical safety checklist for all surgical procedures. The WHO surgical safety checklist aims to decrease errors and adverse events, and increase teamwork and communication in surgery. However, we identified a gap in monitoring that this was implemented. Staff told us checklist records were not audited to ensure they were all fully completed.
- Since our last inspection in 2014, managers within the medicine division said the flow of patients through the hospital remained a risk, but felt this was being well mitigated. Concern remained in relation to capacity in the community, which impacted upon their ability to discharge patients from the hospital. As such, work was being undertaken to address this externally, with stakeholders in primary and social care and strategic health improvement plans within the south-west region.
- Divisional managers told us ward layouts were changed in order to make them safer. For example, in order to reduce violence and aggression in hepatology, patients

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were placed in one, two or four bedded bays, which provided a quieter and calmer environment. However, we visited this ward at night during the unannounced inspection and did not find it to be calm or quiet. We also identified concerns about the management of risk on the hepatology ward in relation to lone working practices when accompanying patients off the ward at night who wanted to smoke. We raised this with the trust who agreed to implement a process written risk assessments to assure this risk was reduced.

- The trust risk register recorded a moderate risk of medicines errors because of the risk of the medicines policy not being understood. A medicine safety officer sub group reviewed medicines errors. This audit reviewed themes and identified learning. All of the reports went to the quality and safety group for their review.
- Management and staff were aware of the risk of the increasing demand for haematology, which was said to be reflective of the national picture. Plans were in place to increase the number of available beds in order to address this. Staff turnover and skill mix in haematology was identified as a risk and was being addressed through recent recruitment initiatives. We were told they were on target to reach full capacity by the beginning of 2017. This would also permit the three, currently unfunded beds on this ward to be opened permanently, as per the operational plan. The divisional managers also reported a plan was in place to address the skill mix in haematology.
- At the time of the inspection, there were concerns raised by a number of senior staff on the oncology and haematology wards relating to staffing and skill mix at night for acute oncology patients. We were provided with assurance that a plan to address concerns about the skill mix of nursing staff at night was being considered. The increased demand seen in the month prior to the inspection was being discussed at ward level, and by senior nursing staff within clinical governance and risk meetings, at the time of the inspection. This provided further assurance the risk was being mitigated. We reviewed the November 2016 clinical governance meeting minutes and saw these issues were being reviewed and monitored closely, and consideration was being given as to whether the risk

related to service provision and or staffing provision. Work on staffing recruitment and retention on the teenagers and young adults' oncology area was also ongoing.

- Managers and senior staff both demonstrated and told us they understood the challenges to delivering high quality care. Actions within and outside the organisation were taken to address them. For example, in the teenagers and young adults ward, there were clear, collaborative relationships with other acute trusts within the region and with national and regional charitable organisations, in order to drive the quality of the service and patient and carer experience.

Leadership of service

- Staff felt leadership was good and divisional lead staff were accessible. Staff told us they felt supported and heard, and there was a collective culture of openness to drive quality and improvement.
- Staff knew who their leaders were within the division. Not all staff were aware of the executive team but said they received weekly emails from executive staff which contained updates about the wider hospital. New staff told us the chief executive was present during part of their induction, where staff were able to ask questions.
- A matron and head of nursing told us on alternate Tuesdays, they worked on the wards in a clinical role. We asked staff from a number of wards, but none were able to confirm having seen this.
- Matrons and ward managers spoke positively about leadership of the trust and felt supported and listened to. They told us divisional managers were visible and approachable.
- We spoke with junior nursing staff and student nurses who told us they felt supported by senior staff. We were given examples when work on wards was stressful, senior staff had supported the junior staff.
- We saw and staff told us, leaders encouraged appreciative, supportive relationships among staff. For example, on the oncology ward, senior nurses were seen to be very supportive of staff during times of emotional distress caused by the death of a patient. They continually checked on staff throughout the day and ensured they took breaks, or were offered the opportunity to seek support if needed. Some staff had taken temporary career breaks and worked in other areas of the hospital, before returning to work on these wards a year or so later.

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- There were strong social networks between younger staff in oncology and haematology which senior staff encouraged, as they recognised the importance of the support this provided, particularly during times of emotional distress due to the nature of the disease area.

Culture within the service

- The culture within the hospital was focused on the needs and experiences of those who used the service and those close to them. We found staff were proud to work at the hospital and we saw staff demonstrate a kindness culture, both to patients and relatives but also to each other. We saw staff across all departments worked together to encompass the values of the hospital.
- Staff spoke of an open culture which was focused on delivering safety and quality. They felt success was celebrated at all levels.
- There was a culture of supporting staff and focusing on staff's wellbeing. Staff were able to access psychological support where needed. This was an initiative that was introduced as a result of feedback from a staff champions meeting. In the cardiac catheter laboratory, some staff practiced Tai Chi prior to a shift, led by a member of staff on the unit. Mindfulness sessions were available to staff in the BHOC. Mindfulness practices are described as a way of paying attention to, and seeing clearly what is happening around us, and promotes wellbeing.
- We were told by some junior doctors they needed a greater consistency of junior doctor cover to enable a sustainable service. They felt this would enable improved learning opportunities for junior doctors.
- However, there were some concerns raised about development and training opportunities. Several band two and three staff explained they did not feel there was a development strategy for them. The band two staff felt there was a lack development potential to progress to band three. Nursing staff told us training in general was not given sufficient priority to ensure it was completed as required. Staff felt other pressures impacted upon their time allocated for such training, which in turn, gave line managers cause to raise completion rates with them.
- There was a strong ethos of teamwork and staff felt very well supported. Staff were very complimentary about line managers and the leadership within the divisions.

Public engagement

- The hospital had forged strong links and worked closely with the voluntary sector. There were many examples of where patients, carers and charities had worked with the hospital to raise fund to improve services.
- The hospital had in excess of 400 volunteers who medical and nursing staff told us went 'above and beyond' to help staff and patients. There was a range of volunteers across the hospital from people who took trolleys from ward to ward selling snacks and confectionary, to those who offered emotional support to patients and families. We observed volunteers on medical wards and in the discharge lounge. They provided conversation and support to patients and staff told us they were a valuable asset to the hospital.
- Leaders and staff demonstrated the participation and involvement of patients who used the service was important to them. Patients were encouraged to raise concerns with staff when they occurred, and to complete the friends and family survey to ensure they gathered the views of those who used the service. We saw on wards across the hospital, display boards which showed results from the friends and family test. Staff told us they encouraged patients to complete these or to provide feedback that would be listened to. We saw examples around the hospital where feedback had been provided and action taken, using the 'you said, we did' format adopted by many NHS hospitals nationally.
- The stroke specialist nursing team had provided teaching into the community. They had spoken with neighbourhood watch groups, police and had spoken on the local radio to provide learning about the stroke services.
- The hospital rolled out initiatives to engage young patients with health conditions, such as congenital heart disease. Young patients on the teenagers and young adults' oncology ward were engaged in the development of services to improve care and adherence to treatment whilst on the ward. Projects included social media and IT, to work collaboratively to develop the content, design and functionality of an on-line emotional support website and an IT-based holistic, needs assessment tool.

Staff engagement

- The trust demonstrated it valued and encouraged staff to raise concerns. A 'Happy App' was developed

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whereby staff flagged and recorded any issues or comments on an electronic tablet device, in order for senior staff to respond. However, for this initiative, the staff's view of the 'Happy App' varied, with some liking the ability to record a concern or comment. Some staff told us they felt this was not always effective and a face to face meeting would have been better. We noted the 'Happy App' comments on some wards were mostly red, an indicator of a negative comment.

- Staff had recently all received a small, laminated card advising them of uniform protocol and the guidelines for wearing staff uniform. Staff told us their views on this card varied with some staff feeling this was an unnecessary expenditure.
- A staff suggestion box had been added on ward A605, for staff to place comments in. We did not find any comments at that time.
- The hospital produced a 'Voices' magazine, for its staff and the December 2015 copy included the recognising success awards. Members of the medical and specialised services division were recognised. Amongst those receiving recognition were nurse specialists, the trust falls steering group, the cardiac catheter laboratories team and the older persons assessment unit.
- The trust recognised individual departments through a nomination and award scheme. For example, staff in the cardiac catheter laboratories had won 'team of the year' in 2016 for embodying the values of the trust. Matron for the cardiac catheter laboratory spoke incredibly highly about the teamwork, skills and commitment of staff within the department.
- In May 2016 the assessment medical unit won a nursing and midwifery award for sustained standards of care delivery during a structural and staff change.
- We saw on ward C808 student nurses had a notice board with details of mentoring. Some student nurses had written cards of thanks to staff for their time on the ward. These cards were extremely complimentary about the support they had received from the ward staff.

Innovation, improvement and sustainability

- Leaders demonstrated a drive for continuous learning and improvement through the ongoing evaluation and monitoring of the service and by delivering projects and

developments aligned to this. We heard many examples from managers and staff that innovation was encouraged. There were a wide number of innovations and initiatives within the hospital.

- The 'Eyes on Legs' project was implemented and training for staff was being delivered in relation to falls management. It was introduced into all mandatory training. The 'Eyes on Legs' project worked on the principle that everybody was responsible to drive accident prevention.
- The trust told us they had been piloting the use of iPads for patients living with dementia. Staff were trained by a group called 'Alive' to understand how to use them with patients.
- There were plans in place to ensure the sustainability of high quality services to patients locally and within the wider region. An arrhythmia nurse-led outreach service into the emergency department and medical assessment unit was planned to start in the New Year (2017).
- Two cardiologists were employed by the Bristol Heart Institute as part of a team of three consultants at a local district general hospital. This ensured a more locally accessible service was provided to the wider population within the region.
- Patients on the teenage and young adults cancer ward were provided with access to an IT-based integrated assessment map, to capture the patients' needs across ten different domains of a young person's life, at the time of transition between child and adult services. It helped staff and patients to identify and discuss individualised needs, plan how these could be addressed and evaluate how these were being met. The teenage and young adults Cancer South West Integrated Assessment Map (IAM) Portal Project used a novel method of undertaking a holistic needs assessment, considering all aspects of the patients' complex needs. This was made accessible to patients via a website and more recently, through the development of an app for use with mobile devices.
- Staff in the teenagers and young adult cancer service continually developed the service and sought funding and support from charities and organisations, in order to make demonstrable improvements to the quality of the service and to the lives of patients diagnosed with cancer. They had worked collaboratively on a number of initiatives. One such project spanned a five year period ending May 2015 for which some of the initiatives were

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ongoing. The project involved input from patients, their families and social networks, and healthcare professionals involved in their care. It focused on key areas which included: psychological support, physical wellbeing, work/employment, and the needs of those in a patients' network.

- Rapid access care of the elderly clinics were established as a way of avoiding admissions to hospital where possible. Divisional leaders informed us they planned to increase this service. However, further recruitment of consultants would be required to enable this to happen.
- The trust launched a virtual ward service with a third party provider in July 2016. The virtual ward specialised in caring for acute patients in their own home through a virtual ward model. The service was available over 24 hours 365 days of the year. It provided patients with the same high-quality level of safe and professional care they would receive in hospital, delivered in the comfort of their own home or place of residence. Since the launch, 113 patients had been cared for within the service consuming 827 bed-days (until end September 2016). The virtual ward had been increasing their virtual in-patient capacity over the last 3 months and at the time of the inspection, were caring for approximately 20 patients at a time, in their own home environment. At present they could accept up to 25 patients. By January 2017, it was planned that the virtual ward would care for up to 35 patients at a time with the virtual ward model.
- A number of new, innovative cardiology procedures were made available to patients at the hospital. For example, in 2015, the Bristol Heart Institute secured funding to offer a procedure to patients suffering from breathlessness and tiredness, due a leak in their mitral heart valve. The procedure was offered to seriously ill patients for whom open heart surgery would have proved high risk, due to co-existing health conditions. The unit was one of three hospitals selected to offer the procedure through NHS England's commissioning through evaluation programme.
- The trust implemented new technology in the oncology centre called the Icon Gamma Knife, in July 2015. This permitted the staff to develop innovative new treatment techniques for patients with a variety of conditions. The trust told us the technology meant patients received safer, effective treatment, with fewer side effects or the need for supplementary medicines, than traditional treatments. For those who were in a palliative phase of life, it achieved tumour control without neurosurgery. The trust was the first in the UK to use this regime. For patients with benign tumours adjacent to critical organs, the team were the first in the world to develop a technique, where treatment resulted in a clinically and statistically significant reduction in the normal brain being treated. It was believed the technique should reduce the risk of side effects in later life, whilst maintaining at least equivalent tumour control.
- The trust informed us more than 100 patients with advanced prostate cancer were treated with a pioneering radium treatment for advanced prostate cancer, which extended life expectancy. They were one of the first in the country to use the treatment, which treated prostate cancer with bony metastases (secondary malignant growths in bone). Staff injected patients with the treatment, which delivered radiation, provided pain relief and extended life expectancy. Men received six injections in total, every four weeks, which took only a few minutes to administer, and had minimal side effects. The Bristol Haematology and Oncology Centre was one of the first centres to start offering this treatment regularly on the NHS starting in February 2014, following a successful trial. The team had helped 14 other centres across the country establish this service. This method allowed for patients to receive prompt care and a reduced number of hospital visits.

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Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Good	●
Well-led	Outstanding	☆
Overall	Outstanding	☆

Information about the service

Surgery services at University Hospitals Bristol NHS Foundation Trust were delivered from five of the seven hospitals which make up University Hospitals Bristol main site. These were:

- The Bristol Royal Infirmary
- The Bristol Heart Institute
- The Bristol Eye Hospital
- University of Bristol School of Oral & Dental Sciences
- St Michael's Hospital

Adult theatres and recovery, known as Hey Groves, were based in the Bristol Royal Infirmary and included ten theatres and nine recovery beds. The Bristol Heart Institute was co-located within The Bristol Royal Infirmary and utilises the Hey Groves theatres. The Queens Day Unit was also within the Bristol Royal Infirmary and included two theatres and four recovery beds. Endoscopy was co-located within the Queens Day Unit and included four rooms and two second stage recovery areas (male and female). In the Bristol Royal Infirmary there were 6 wards and 147 beds. In addition, there were 8 chairs on STAU for ambulatory attendances. The Bristol Eye Hospital had four theatres and three recovery beds and two wards with 28 beds. Eleven of these beds were inpatient beds (on Gloucester Ward) with the remaining 17 on a day case ward. The University of Bristol School of Oral & Dental Sciences had one day case theatre and four day case beds.

Surgery services were also provided at St Michael's Hospital (on the Bristol Royal Infirmary main site) and South Bristol Community Hospital. In St Michael's Hospital three theatres

were dedicated to gynaecological surgical procedures and two were dedicated to obstetric surgical procedures. At South Bristol Community Hospital there were two day case theatres and an endoscopy service. However, we did not inspect these services during this inspection.

Adult surgery was based within the Surgical Head & Neck division and was divided into eight services. These were anaesthetics, dental, ear nose and throat & thoracic, eye, gastrointestinal, intensive care, theatres, and trauma and orthopaedics). Although critical care was within the Surgical Head & Neck division we did not inspect this service during this inspection. Cardiac services were based within the specialised services division.

During the reporting period (April 2015 to March 2016) there were a total of 27,751 surgical spells across the whole of the trust. There were 23,769 surgical spells for the areas we inspected.

During the last inspection visit between 10 September 2014 and 12 September 2014 and unannounced inspection on 21 September 2014 we rated surgical services as requires improvement for safe, effective, responsive and well led, with caring being rated as good. Compliance actions were issued based on breaches found of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Breaches in the regulations included regulation 9 (for discharge planning), regulation 13 (for medicines management), regulation 14 (for meeting patients nutritional needs), regulation 17 (for patients staying overnight in recovery without adequate privacy and dignity), and regulation 22 (for insufficient staffing),

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During our announced inspection between 22 November 2016 and 24 November 2016, we visited the University of Bristol School of Oral & Dental Sciences and two wards at the Bristol Eye Hospital. At the Bristol Royal Infirmary we visited the Hey Groves and Queens Day Unit theatres (including endoscopy) and their recovery areas. We visited five wards in the Bristol Royal Infirmary, the discharge lounge, the surgical and trauma assessment unit and two wards in the Bristol Heart Institute.

We spoke 67 staff, 30 patients and their relatives and looked in nine sets of patient records. We performed an unannounced inspection in the evening of 1 December 2016 and revisited a ward and revisited the surgical trauma assessment unit. During this time, we spoke with an additional four members of staff and four patients.

Summary of findings

We rated surgery services as outstanding because:

- There was a good culture of incident identification, reporting, investigation, and sharing of learning throughout the surgical division. There were many examples shared with inspectors of learning from incidents both in their own area and from the wider trust.
- Staffing levels were good with only occasional use of agency staff. Where there were shortages of staff there was a quick response to rectify this. This resulted in safe staff management and handover from staff to manage risks.
- Risks were managed and responded to effectively both on the wards and in theatre. We saw examples of the World Health Organisation surgical safety checklist being utilised effectively to keep patients safe. Learning from a never event was fully integrated into the surgical safety checklist. On the wards we saw comprehensive risk assessments, which included physical and mental health, to ensure the safe care and treatment of patients.
- Mortality rates were better than the England average. Patient outcomes were recorded and audited. For example, the trust performed well on the bowel cancer audit, and there was demonstrable improvement in the national emergency laparotomy audit.
- Staff worked effectively together as a multidisciplinary team and worked together in a coordinated way for the patients best interests. This included working between teams and services.
- Feedback from patients and their families was consistently very positive. Patients we met spoke positively of the service they received and of the compassion, kindness and caring of all staff. Staff ensured patients experienced dignified and respectful care. Relative of patients were fully involved in patient care and the staff ensured that strong relationships were built to ensure a high quality of care.

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- Friends and family results were always positive and response rates were better than the national average. We saw many examples of person-centred care which had a positive impact on patients' wellbeing.
- Although slightly limited, reasonable adjustments were made for patients living with dementia or with learning difficulties including use of the 'this is me' document and patient access to activities.
- Leadership in the trusts surgical services was enthusiastic and staff were motivated to succeed. We found the strategy for the division was clear and had supporting objectives which were challenging, supportive and innovative. A strong governance structure aided managers to proactively review performance and risks and were reviewed to reflect best practice.
- We saw an innovative method of engaging staff through the use of the 'Happy App' and proactive engagement with staff. We found because of this the culture of engagement had developed to be positive. Staff were proud to work at the hospital.

However:

- Not all staff within the surgical service had received recent mandatory training to keep patients safe. There were a number of staff who had not completed all of the required training for resuscitation, safeguarding, fire, manual handling and infection control.
- Outcomes could have been improved for the national hip audit. However, the service provided at this trust was relatively small compared to other trusts of a similar size.
- The service was planned and delivered in a way which met patient's needs. However, some patients had long waiting times to have their surgical procedure. This was particularly apparent in the cleft palate service and the dental service.

Are surgery services safe?

Good



We rated this service as good for safe because:

- Safety performance showed a good track record and steady improvements. When something went wrong there were thorough investigations were carried out. Lessons were learnt and communicated widely to staff, to support improvement in other areas as well as services which were directly affected.
- When something did go wrong patients received a sincere and timely apology in line with duty of candour regardless of meeting the duty of candour threshold. This was recorded in patient records.
- There were clearly defined systems, processes and standard operating procedures to keep patients safe and safeguarded from abuse. We were given multiple examples by staff where they had taken steps to prevent abuse from occurring, and responding to any signs or allegations of abuse and worked with the safeguarding team and the local authority to ensure patients were protected.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. The use of bank and agency staff was low. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff can manage risks to patients who use services.
- Patient records showed risks to patients were assessed, monitored and managed on a day to day basis, including the identification of deteriorating health. We saw good use of the World Health Organizations safer surgery checklist. We found staff were fully engaged with this and it was conducted appropriately.
- Standards of cleanliness and hygiene were well maintained. Wards were visibly clean and there were records to evidence regular cleaning and decontamination.

However:

- Not all staff had received up to date training in all safety systems. Compliance rates for mandatory training were below the trust's 90% target for medics and dentists and administrative staff. However, nursing and allied health professional staff were above the target.

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Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and report them. All staff we spoke with were clear about the processes involved when reporting an incident and were confident to do so. Between September 2015 and August 2016 there had been an increase in the number of incidents reported (from 6.5 incidents per 100 patients to 7 incidents per 100 patients) and a decrease in the number of serious incidents reported. This indicated an improving safety reporting culture.
- The safety performance over time was good and surgical services performed well compared to similar services in other trusts. Between October 2015 and September 2016 there was one incident classified as a never event. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systematic protective barriers are available at a national level, and should have been implemented. A specimen meant for transfer to histology was left in a patient in a bag. The root cause analysis and learning from the never event were ongoing at the time of our inspection. Immediate additional safety checking systems were implemented and integrated into the World Health Organisation safer surgery checklist to ensure all histology samples were removed from theatre prior to finishing the operation.
- In accordance with the Serious Incident Framework 2015, surgical services reported nine serious incidents, which met the reporting criteria set by NHS England between October 2015 and September 2016. Of these the most common type of incident reported was sub-optimal care of a deteriorating patient, falls, surgical incidents, pressure ulcer, and diagnostic incidents. In response to the increased incidents in the care of the deteriorating patient, a project team was put together to investigate, the results of which highlighted further training was required. During the inspection we saw scheduled training sessions for staff to attend.
- When things went wrong, thorough investigations were carried out in a timely way and all relevant staff and patients were involved in the investigation. Between April 2016 and August 2016 there had been two serious incidents reported. Both of these had a 72 hour investigation report and a root cause analysis completed within the correct timescale. Examples of root cause analysis seen were completed to a high standard. There were comprehensive action plans which included immediate and medium term recommendations. Recommended learning was identified and disseminated as identified.
- Some incidents occurred on the wards had a post incident debriefing known as a 'SWARM'. A SWARM was initiated as soon as possible after an adverse or undesirable event has occurred. This allowed staff to discuss the issues and to share immediate learning and would be used in conjunction with the trust incident reporting policy.
- Lessons were learnt and action was taken as a result of investigations. In theatres changes had been made to insulin packs as a result of the learning identified following the investigation of a near miss (a near miss is an incident which was picked up before harm was caused). This included storing insulin packs in theatre fridges along with a laminated information sheet and guidelines for drawing up the insulin. Departmental training and a trust-wide safety bulletin was also put in place.
- Learning was shared to make sure action was taken to improve safety beyond the effected team or service. Staff we spoke with said they received feedback and individual learning from incidents. Minutes of local team meetings demonstrated sharing of learning between departments and services. These were supported by using posters and newsletters. 'Learning after Significant Event Recommendations' (LASER) leaflets were in circulation and were displayed on ward notice boards. Examples of these included an incident involving an air embolism and an incident involving the non-detection of raised blood ketones. These leaflets had information on the patient story, learning from the root cause analysis and a list of recommendations. Other leaflets included the 'Governance Grapevine', which was released monthly within the division and shared divisional wide messages on incidents.
- Learning sessions were also put in place on wards to reinforce the lessons learnt from incidents and to give staff the opportunity to ask questions.
- Staff gave us multiple examples of learning from incidents and how practice had changed on their own ward, and in the wider directorate.
- Multi-professional surgical mortality and morbidity reviews were held regularly. Learning was shared at these meetings and was then disseminated through

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clinical educational sessions and team meetings. We saw multiple examples where the learning taken had fed into service improvement, including changes to processes. Where concerns were raised investigations were carried out to improve the service. For example, as a result of mortality data around the fractured neck of femur service The British Orthopaedic Association was asked to review the data and produce recommendations.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff at all levels in the service had a good understanding of the duty of candour and could describe when it would be used.
- Incident reports seen showed adherence to the duty of candour regulation, including processes and evidenced written apologies. There was a check list within the root cause analysis process which ensured the duty of candour was considered. This had to be completed within ten days of the reported incident to ensure the patient and family were involved and apologised to at the earliest opportunity. We saw evidence this was used effectively.

Safety thermometer

- The NHS patient safety thermometer is used to record the prevalence of patient harms at ward level, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data collection took place on one day each month.
- Between September 2015 and September 2016 the division reported six pressure ulcers, one fall with harm, and five urinary tract infections. Learning had been identified for all three measures and was shared across the whole division to promote awareness and reduce occurrences with other patients. For example, to raise awareness of pressure sores, a designated lead had been introduced into ward areas. This individual had

introduced training for staff in the detection of a potential pressure ulcer, made learning from pressure ulcers visible to all staff, and worked towards “changing the mind-set of the nursing staff”.

- National Institute of Health and Care Excellence quality standard 3 statements 1 and 3 state all patients upon admission should receive an assessment for the risk of venous thromboembolism and bleeding and should then be reassessed within 24 hours. The divisional quality scorecard between April 2016 and August 2016 showed 99.2 percent of patients received care met these standards.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were well maintained. There were cleaning rotas and signing sheets in the wards for the cleaning of equipment including the resuscitation trolley and drip bag stands. We also found bathroom and toilet cleaning records were on display, as were tap flushing records. In endoscopy we found there was a recovery work area cleaning checklist which was signed on a daily basis. We found in ward and theatre areas that they were all physically clean and tidy. Equipment we checked was also physically clean. However, we found the Queens day unit and the endoscopy suite shared a dirty utility room where clean equipment was stored. There was an increased risk of contaminating equipment due to the presence of bodily fluid coming into this area for disposal.
- There were reliable systems in place to prevent and protect patients from a healthcare-associated infection. We saw an example on the surgical trauma assessment unit where a patient was quickly moved from a bay to a side room when they found inconclusive results to a methicillin-resistant *Staphylococcus aureus* swab. We found on all of the wards we visited there were sufficient side rooms to manage the needs of patients requiring isolation. We found staff were always wearing personal protective equipment when entering the room and disposed of it immediately when leaving. However, some staff told inspectors they sometimes didn't see doctors wearing personal protective equipment when going into side rooms.
- Trust policies on hand washing and infection prevention and control were not always followed. The National Institute of Clinical Excellence Quality Standard 61 Statement 3 states ‘people should receive healthcare

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from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care'. Observations made on ward A700 showed out of ten opportunities to gel hands only three staff done so which increased the risk of spreading infections. However, this was not reflected in the surgical services hand hygiene audits which were completed on a monthly basis. Results were positive year on year and did not drop below 97%. We also found on ward A700 and A800 hand gel was not always located at the entrances which discouraged visitors from gelling when entering the ward. We also found there were no information displayed to visitors to highlight the importance of decontaminating their hands to reduce the spread of infection. Staff on a cardiac ward explained to inspectors additional training had been introduced when their scores dropped slightly which included training sessions with the infection control specialist nurse and sessions with a glow box.

- The rate of infection was similar to the England average. There were no methicillin-resistant *Staphylococcus aureus* bloodstream cases and only four cases of *Clostridium difficile* and four cases of methicillin-sensitive *Staphylococcus aureus* between April 2016 and August 2016.
- We found in theatres that processes to decontaminate patients and staff pre and post operatively to reduce the risks of surgical site infection were in line with the National Institute of Clinical Excellence clinical guidance 74. This included the showering, hair removal, appropriate uniform for staff and theatre ware for patients, nasal decontamination, bowel preparation, removal of jewellery, and the management of staff leaving the operating theatre, sterilisation and skin preparation. Surgical services submitted data to public health England for the surveillance of surgical site infections. Between April 2015 and March 2016 of the 33 hip replacement operations and 90 reduction of long bone fracture operations done of them had surgical site infections. Of the 199 repair of neck of femur operations done only two had a surgical site infection (one percent) which was comparable to the England average.
- The trust managed and decontaminated reusable medical devices in line with national guidance which resulted in the sterile services department gaining International Organization for Standardization accreditation. There were clear processes in place to ensure there was separation and tracking of sterile and

non-sterile equipment. Of the 12,000 items of medical equipment that were decontaminated each month by the SSD only two items within a three month period were returned due to the instrumentation being unsterile (broken packs) and four were returned due to a hair or suture being on the instrument set. Where items were found to be unsterile they could be tracked back to the individual who packed it to ensure learning was supported.

Environment and equipment

- The design, maintenance and use of the facilities and premises kept people safe. All areas inspectors visited were well maintained and tidy.
- The maintenance and use of equipment kept people safe. Resuscitation equipment was always available in ward environments. We checked eight pieces of equipment in the main theatres, endoscopy and in the queens day unit and they all had up to date service stickers. Equipment was managed by a central team. Staff we spoke with in theatres described to us how they would report faulty equipment and when this happened it was dealt with quickly by the Medical Equipment Management Organisation. Staff reported any faulty equipment via the electronic reporting system and all the staff we spoke with were confident in how to complete this process.
- We checked three resuscitation trolleys during the inspection and two resuscitation trolleys during the unannounced inspection. The resuscitation equipment and trolleys were visibly clean and free from dust. There was evidence of daily and weekly checking of the equipment on the trolleys and the trolleys were sealed with tags to show they had not been tampered with since these checks. The queens day unit audit data from June to November 2016 showed poor compliance with daily checking and was rated non-compliant by the trust however, when we reviewed one months of recorded checks all were completed, signed and dated. This was evidence of learning and improved practice. We reviewed the daily equipment checklists in the Queens day unit and saw one month's checks were fully completed and signed for. The list included checking expiry dates of emergency drugs, calibration of the blood sugar monitor, and re stocking of essential items.
- Trust policy stated the anaesthetic equipment should be checked daily and recorded in a log book. We checked the log book in Hey Groves theatre 5 which was

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started on 4 July 2016, nine signatures were missing. We could not find the log book in theatre 7 and reported this to the theatre staff. The log book in day theatres had too many signatures missing to count. We escalated this to the theatre manager who assured us that the daily equipment checks were always completed but staff often forgot to sign that they were completed.

- Arrangements for managing waste and clinical specimens mostly kept people safe. The wards, pre-admission area and theatres had suitable quantities of properly assembled sharps bins in use and stored for replacement. We found these bins were not overfilled and closed when in use. However, we saw one sharps bin in the surgical trauma assessment unit during our unannounced inspection which was filled above the fill line as a syringe was sticking out of the top.

Medicines

- Arrangements for medicines management kept people safe on the majority of the ward and theatre areas we visited. Controlled drugs (CDs) were stored, prepared and disposed of in line with the Safer Management of Controlled Drugs Regulations. Intravenous fluids were stored safely and trained nurses held keys to all drugs trolleys and cupboards. However, we saw eye drops had been left on an open shelf on an inpatient ward in the eye hospital. These could have been tampered with or removed by an unauthorised person. The stationary books used to order, return or distribute CDs were stored securely, access was restricted and they were kept in a locked cupboard. We checked a number of stocks and the registers and found them to be accurate. Apart from one missing signature, all CD books had two signatures to ensure safe removal and administration of a CD; the missing signature was escalated to the matron.
- Of the six medicines trolleys we looked at we found they were all securely locked and attached to the wall via a wire to prevent removal.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations.
- There were manageable levels of stocks to prevent medicines going out of date and reducing the risk of errors.
- We checked a number of medicine fridge temperatures on several wards and two of the theatre areas and saw

they were all recorded and within the correct range (between 2°C and 8°). We asked staff what they would do if the temperature was outside of the correct range, and they told us they would escalate this to the pharmacy department and the nurse in charge.

- Hypoglycaemic boxes were provided on the wards and were easily accessible in case of a diabetic hypoglycaemic emergency. The boxes we saw all had clear guidance of what to do in such an emergency and all were fully stocked.

Records

- We looked at seven patient records in different wards in surgical services. Of the seven individual care records we looked in we found they were written and managed in a way that kept people safe (including ensuring people's records were accurate, complete, legible, and up to date) which was in line with the records management code of practice for health and social care. All documentation reviewed was signed, dated, legible, with clear communication from the nurses, consultants and allied health practitioners. On A700 they were piloting integrated medical and nursing records and found this was working effectively. Staff said it improved multidisciplinary working between professionals and ensured all staff were fully informed when managing patient care.
- We looked at the records for two patients who were due to be discharged. When a patient was due to be discharged we found all relevant documentation was filled in and ready for ongoing care including information on medicines, surgical intervention and care requirements and access to a telephone number for concerns.
- We looked in two pre operation assessment records and found they were also written and managed in a way that kept people safe. We found the records to be accurate, complete, legible and up to date and included all relevant information from the anaesthetist and consultant which was in line with the records management code of practice for health and social care.
- We found records were mostly held securely in lockable records trolleys. However, in the Queens day unit and the surgical and trauma assessment unit these trolleys were not available. These records could have been tampered with or removed without authorisation.
- Additional information on wards was displayed on white boards. This showed the patients name, risk of falls

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status, pressure care status, cognitive status, therapy status, and when their next consultant review was. All patients signed a consent form to say they were happy for this information to be displayed. Although the board looked busy all staff we spoke with were familiar with how it worked and the information it displayed. These boards were used and updated as part of the morning safety brief and ward board rounds.

Safeguarding

- The trust safeguarding policies described the definition of abuse and who might be at risk. These policies were easily accessible on the trusts intranet pages along with information provided by the trusts safeguarding team (including contact details and phone numbers). Despite the levels of safeguarding training people understood their responsibilities and adhered to safeguarding policies and procedures.
- The staff working in surgical services generally understood their responsibilities to safeguard adults and children despite training levels being below the trusts 90% target. At June 2016 only 67% of medical and dental staff had completed level two adults and level two children's safeguarding training. The percentage of nurses who completed level two adults safeguarding training was 95% which was better than the trusts 90% target. However, level three was only 75%. Although near the trusts 90% target only 89% of nurses had completed safeguarding level two training. Despite this we were given multiple examples of where safeguarding referrals had been made based on allegations of abuse. We were also given examples about where parents with children under the age of 18 had to stay in overnight and ensuring referrals were made to ensure the child's safety. We observed care on the surgical trauma assessment unit where members of the public were refused access to a patient due to an alert being raised and the hospital informed. Staff on wards told us they regularly received feedback from the safeguarding team when they made a referral.

Mandatory training

- Most nursing staff received effective mandatory training in the safety systems, process and practices which kept people safe. In October 2016 92.6% of nursing staff within surgical services had received all the appropriate training compared to a 90% trust target. Conflict awareness training rates were 98%, conflict resolution

training rates were 97%, equality and diversity training rates were 98%, infection prevention and control training rates were 95%, medicines management training rates were 95% and patient safety training rates were 93%. However, information governance training rates were 78% and manual handling training rates were 88%. In line with the National Institute of Clinical Excellence guideline 51 training had been rolled out to nursing staff for the recognition, diagnosis and early management of sepsis. Staff we spoke with had received training in the application of the sepsis protocol and could direct inspectors to the sepsis management policy.

- All health care professionals received effective mandatory training in the safety systems, process and practices which kept people safe. In October 2016 95% of health care professionals within surgical services had received all the appropriate training compared to a 90% target. Conflict resolution awareness training and equality and diversity training rates were 100%, conflict resolution training and infection prevention and control training were at 97%, and information governance, manual handling training and patient safety training were at 90%.
- Not all medical and dental staff had received effective mandatory training in the safety systems, process and practices which kept people safe. In October 2016 65% of medical and dental staff within surgical services had received all the appropriate training compared to a 90% trust target. Conflict awareness training rates were 75%, conflict resolution training rates were 68%, equality and diversity training rates were 76%, infection prevention and control training rates were 66%, information governance rates were 38%, manual handling rates were 59%, medicines management training rates were 65% and patient safety training rates were 64%. This means doctors and dentists were not suitable equipped to keep patients safe.
- Not all administrative and clerical staff received effective mandatory training in the safety systems, process and practices which kept people safe. In October 2016 85% of administrative and clerical staff within surgical services had received all the appropriate training compared to a 90% target. Conflict resolution and awareness training rates were 96% and equality and

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diversity training rates were 97% which were above the trusts target. However, infection prevention and control rates were 87%, information governance rates were 59%, and manual handling rates were 88%.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients who use surgical services. Risk management plans were developed in line with national guidance and risks generally managed positively. Patients had risk assessments carried out during their pre-admission appointment which included assessments for falls and malnutrition universal screening tool and venous thromboembolism as per National Institute of Clinical Excellence quality standard 3. Of the seven records we looked in on wards we found actions resulting from risks assessments were all completed and reassessed on an ongoing basis in line with trust protocol. Additional risks, such as allergies were identified during admission and patients would have a different colour identification wristband to raise awareness of this to staff.
- Staff identified and responded to changing risks to patients who use surgical services. There was a hospital wide standardised approach to the detection of the deteriorating patient with a clearly documented escalation response, in line with the National Patient Safety Agency guidelines. The national early warning scores were used within the hospital. Records were in place for each patient and were completed and calculated in all of the records we saw.
- National early warning scores scoring was audited on a monthly basis and identified 76% compliance in recording and escalating of the deteriorating patient between April and October 2016 which was a decline of results from a previous year. This was a decline in compliance from April 2015 to March 2016. An investigation conducted before the inspection highlighted what the issues were and an action plan was put into place to feedback results to all staff across the trust, continue with individual ward monthly audits and conduct teaching for all staff.
- Doctors we spoke with were positive about how national early warning scores were being used effectively on the wards. Training in how to use national early warning scores was part of nurse induction and ongoing essential learning and ensured staff escalated and responded appropriately. Nurses we spoke with

said they could easily contact a doctor of necessary. We were given examples where if a score changes a doctor attends within 15 minutes. If necessary the consultant can be called and they will also be there quickly.

- In all operations we observed, the National Patient Safety Agency five steps to safer surgery were being followed as part of the World Health Organisation (WHO) surgical safety checklist. This included a surgical briefing, signing in, time out, signing out and debriefing. The briefing was an opportunity for the operating or interventional team to share information about patients and discuss potential and actual safety issues before the theatre list takes place. Staff present included theatre nurses, operational departmental practitioners, anaesthetists, surgeons, specialist registrars and scrub nurses. We saw how the team planned the mornings theatre sessions, discussed specific equipment that may be required and had updates from surgeons and anaesthetists regarding complex patients with comorbidities. The WHO surgical checklist formed part of a procedure carried out to scrutinise all safety elements of a patient's operation. This included, checking the correct patient, the correct operating site, consent had been given, and all the staff were clear in their roles and responsibilities. The hospital was committed to ensuring all surgical procedures completed the surgical safety checklist. The hospital monitored audit data over the 12 months prior to our inspection, which showed the theatre department were 99.6% compliant with the WHO surgical safety checklist. One member of staff we spoke with said there had been "a massive culture change" around the checklist and they felt they had "the freedom to speak up without repercussions".
- The dental hospital had adapted its checklist in response to historic never events. There were standardised procedures across this and other departments in the trust and we saw how the nursing staff were empowered to facilitate the checklist and every member of the team was fully engaged in the process.
- The hospital had a National Safety Standards for Invasive Procedures (NatSSIPs) workgroup in order to streamline practice across the hospital. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs), which were embedded.

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- There was a clear triage process in place for patients who went directly to the surgical trauma assessment unit. This occurred when GP practices directly referred patients. We saw an example where a patient was seen for an initial nursing assessment within 15 minutes of their arrival. This included a full set of clinical observations, documentation of their relevant past medical history and a pain assessment score. We also found there was a clear risk assessment process for medical patients coming from the medical admissions unit onto the surgical trauma assessment unit. During the unannounced inspection we observed a nurse individually assessing a patient who was being transferred from the medical assessment unit and challenged records and assessments in line with the hospitals bed management standard operating procedure.
- Sickness rates between April 2016 and August 2016 were 4%. However, the trust identified turnover was a risk with the average turnover between April 2016 to September 2016 being 14%. This was lower than the England average.
- Arrangements for handover and shift changes ensured people were kept safe. We saw a system of staff handover in the surgical trauma assessment unit whereby staff spent time studying the handover sheet, then had a patient inclusive bedside handover, followed by a whole team discussion of patients and safety briefing. During this handover patient charts, ongoing investigations, risk assessments, consent, and discharge were all discussed. We saw staff were engaging with patients during this process. A handover checklist was in use between theatre and recovery staff which had been introduced since the last inspection. Staff were given time to complete this and staff we spoke with had found the handover had significantly improved.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so people received safe care and treatment at all times, in line with trust policy. Acuity and dependency were reviewed on a daily basis and staffing was adjusted to meet the demands on the wards. Bed meetings were held at 8:30am and 2:30pm on a daily basis to assess bed flow and staffing in the hospital.
- We found staffing levels were good and actual staffing figures matched those planned. We found where risks were greater staffing levels were increased to match this need. For example on an orthopaedic ward we found additional staffing were available to care for patients living with dementia. On another ward we found that where a patient required one-to-one care additional staffing was available to meet these care needs. We looked at shift fill rates surgical services in October 2016 and found that of the seven surgical wards the fill rate was above 100% for all wards apart from The Bristol Eye Hospital where fill rates were 98%. Some wards had significantly higher fill rates than others with Ward A602 having a fill rate of 117% and ward A604 having a fill rate of 113%.
- Use of bank staff and agency staff were low, with bank staffing levels remaining consistently below 5% and agency staffing levels remaining consistently below 2% between September 2015 and August 2016. Overtime of staff was constantly below 1% of staffing expenditure during the same period of time.

- We found arrangements for shift changes ensured people were kept safe. During shift changes bedside handovers were completed which were inclusive of the patient going through updates for the day, and nutrition and hydration status. After a bedside handover a team safety brief was conducted where all patients were discussed again as a whole team and discussed discharge arrangements, and risk statuses.

Surgical staffing

- Surgical services had a planned medical staffing level of 505 whole time equivalents (the number of people working full time employed by the trust. As of June 2016 vacancy rates for surgical services were 4.2% with a turnover rate of 39.5% and a sickness rate of 0.7% which was in line with the England average. The use of bank and locum staff was 1.9% which was lower than then England average. In September 2016, the proportion of consultant staff reported to be working at the trust were about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.
- Staff we spoke with said there was adequate consultant presence at the weekends within surgical services. We spoke with consultants and anaesthetists who commented that work had been done to improve the fractured neck of femur pathway to ensure lists were running seven days a week with very few gaps in the rotas.

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- Medical staff were not undertaking twice daily ward rounds. However, risks involved were being proactively mitigated to ensure safety to patients. Consultant ward rounds were done every Tuesday, Thursday, Friday, Saturday and Sunday. Patients had a consultant review each day in the afternoon. Registrar ward rounds were held on a daily basis with input from consultants if necessary.
- Anaesthetists reported frustrations when predicted staff vacancies were not recruited into in a timely manner. Staff reported to us when they identified future staffing shortfalls such as retirement, they were not able to start the recruitment process early enough to mitigate the staff shortage.

Major incident awareness and training

- Potential risks were taken into account when planning services such as the impact of adverse weather or disruption to staffing. Surgical services had a business continuity plan which detailed actions that should be taken in response to various extreme circumstances. Risks to the service, such as power disruption in theatres, were on the surgical services risk register.
- There were arrangements in place to respond to emergencies and major incidents. We saw the trusts major incident, escalation and extreme escalation plans which detailed actions which should be taken within surgical services during times of extreme pressure upon the service. Action cards were used to ensure responsibilities were understood and processes were followed. Actions, such as the cancellation of elective lists and the reallocation of staff were appropriate for the level of risk to the service. Staff we spoke with understood their responsibilities within the major incident plan and discussed the importance of using action cards. Many staff could describe the process involved for the opening of the 21st bed in ITU and the impact that would have on the rest of the hospital as described in an escalation standard operating procedure.

Are surgery services effective?

Good



We rated effective as good because:

- Patients had comprehensive assessments of their needs, which include consideration of clinical needs, including both mental and physical health and wellbeing, nutrition and hydration needs.
- Pain relief, nutrition and hydration were managed well. There were clear pathways for managing pain which were in line with evidence based practice. People had their nutritional and hydration needs fully assessed and met in line with best practice. Patients we spoke with were positive about the quality of care received.
- Staff were qualified and had the skills they need to carry out their roles effectively and in line with best practice. Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Through this the learning needs of staff were identified and training was put in place to meet them. Staff were supported to maintain and further develop their professional skills and experience.
- We found there was good multidisciplinary working and people received care from a range of different staff, teams or services, in a coordinated way. All relevant staff, teams and services are involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Mortality rates in the trust were good. Rates of mortality for the national hip fracture audit, bowel cancer audit and the national oesophago-gastric cancer audit were better than the national average. Outcomes for people who used the services were in general good for example in bowel cancer audit and the oesophago-gastric cancer national audit and had an improving picture for the national emergency laparotomy audit.

However:

- The trust was performing worse than the national average in some elements of the hip fracture audit. However, the service provided at this trust was relatively small compared to other trusts.
- Appraisal rates could have been improved. The trust had a target of 85% completion of appraisals but only 77% of staff in the surgical division had received this. Administration staff had the lowest rates with only a 66% completion rate.

Evidence-based care and treatment

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- Relevant and current evidence based guidance; standards, best practice and legislation were identified and used to develop the service through various steering groups within the Surgery, Head & Neck division. Examples of these steering groups included the nutrition and hydration steering group which had developed standard operating procedures in line with best practice and guidance for 'cancelled operations/procedures and nutritional needs', and nil by mouth patients. Another example included the tissue viability group which used best practice and guidance to develop processes to prevent pressure sores, with a focus on medical equipment such as oxygen masks and nasal tubes. Product trials were underway at the time of the inspection for alternative products to further relieve pressure in these areas. A working group for anaesthetists used best practice guidelines and results from the hip fracture audit to introduce new anaesthesia guidelines. Also the introduction of an improved block anaesthetic system to enhance post-operative analgesia for limb surgery and introduced a wound catheter and elastomeric pump service which, based on an audit of 225 cases, has improved the overall length of stay of patients by three days.
- Patients had their needs assessed and their care planned and delivered in line with evidence based, guidance, standards, and best practice. Care plans, risk assessments, food charts, blood sugar monitoring, fluid charts, observation charts, drug charts and signature sheets were all standardised throughout the trust and were developed in line with best practice recommendations and guidance.
- Staff described the 'Sepsis Six' pathway for identifying and treating sepsis, in line with National Institute for Health and Care Excellence (NICE) guidance (NG 51). Clinical staff were trained in the identification and rapid treatment of sepsis and this was also included in the nurse's induction study days.
- In order to streamline practice across the trust National Safety Standards for Invasive Procedures (NatSSIPs) for specimen checking was in the process of being implemented and posters were printed and ready to be displayed. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures.
- The pre-op assessment area made good use of technology to improve its effectiveness. Video recording

of assessments had also been introduced for high risk patients to allow them to use this information alongside data collected in the clinic. Also, some patients had their clinics held remotely though video link which has significantly reduced the waiting times for patients.

Pain relief

- Surgical services had pathways and guidance in place to ensure people had pain relief and improvements were being made based on evidence based practice and guidance. Many guidelines on pain management had been introduced since the last inspection. These included 'intrathecal spinal anaesthesia – management for adult inpatients'; 'Local anaesthetic infiltration via elastomeric pumps'; 'insertion and management of wound infiltration catheters and elastomeric pumps'; 'ketamine infusion for pain relief in adults'; 'Analgesic prescribing for in-patients with acute pain and illicit opioid dependency'. This ensured pain pathways were being followed.
- Audit work had highlighted how patients who had sustained rib fractures were at higher risks of developing complications (such as chest infections) due to poor pain management restricting breathing. A new algorithm and guidelines on managing these patients has been disseminated and will be re-audited. A sticker had also been introduced as part of the patient records to identify patients during ward rounds to ensure follow up of pain medication. A weekend handover sheet was also introduced to ensure effective transfer of information between teams.
- Every patient we spoke to told us they had been given adequate pain relief. Patients told us when they required extra pain relief the nurses responded to call bells efficiently and administered the medication swiftly.

Nutrition and hydration

- Patients' nutritional needs were assessed and met using a 72 hour food chart review. This documented a patient's intake over the course of 72 hours which was then rated to see if any action was required. We looked in seven sets of patient notes and found they were all completed with actions of continuing assessments, no assessments needed, or intervention needed. This was audited on a monthly basis and between April 2016 and August 2016 these charts were completed 91.4% of the time.

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- Pre-operative comfort rounds were used in the pre-operative areas to ensure patients were adequately hydrated while waiting for their surgery. A 'Comfort Round' would take place on an hourly basis and patients would be offered a drink of water or a clear carbohydrate drink they would also have their temperature checked. There were criteria for patients who would be considered high risk who would have a greater level of monitoring.
- We spoke with 23 patients on the wards and in the discharge lounge, all except one patient reported the choice and standard of food was good. One of the patients on the ward had been in the hospital for approximately three weeks and although had been on a soft diet reported the food was still excellent. Another patient we spoke with who had been on a restricted diet felt it had been managed well and one other patient told us how he had received a diet specific to his religious needs.
- A new breakfast service format was trialled on one of the wards. The aim was to provide staff with a structured 'all hands on deck' plan with who does what, when and how. As this ensured a more efficient and timely service it was implemented on other wards around the trust.

Patient outcomes

- Surgical staff regularly reviewed the effectiveness of care and treatment through local audit and national audit.
- There was very little orthopaedic work carried out at the trust with a majority of this patient group being treated at another NHS trust in the city. Therefore, the numbers of people that the hip fracture audit relates to is relatively small. The hip fracture audit looks at key parts of a patient's journey after receiving a hip fracture and analysis its timeliness due to the importance of getting surgery within 36 hours of arrival to the emergency department. The mortality rates for the audit were better than the England average and were better in the 2015 audit than in the 2014 audit. However, the proportion of patients having surgery within 36 hours was only 74% in the 2015 audit, which is worse than the national standard of 85%. The percentage of patients receiving an orthogeriatrician assessment within 72 hours was only 94.1% compared to a national standard of 100%. It was identified in the 2015 audit just under 5% of patients developed a pressure ulcer which puts the trust in the worst 25% of all trusts for this measure. In addition, length of stay was reported as 25.5 days,

which puts the trust in the worst 25% of all trusts for this measure. Although the audit was only completed on a yearly basis it was measured internally on a monthly basis. Performance in July 2016 was improved but only slightly. The reasons given for these results were displayed in an action plan which stated that during busy times, for example when two fractured neck of femurs are admitted on the same day, it can be difficult to ensure surgery within 36 hours alongside other urgent surgery targets. In addition, due to the lack of orthogeriatrician cover over weekends and annual leave, along with significant long term sickness other measures of the audit were difficult to achieve. Work was underway to change the working model for this specialty and funding had been agreed to increase orthogeriatrician staffing.

- In the 2015 Bowel Cancer Audit, 63% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate of 69% and worse than 2014 data. The 90-day and two year post-operative mortality rate (risk adjusted) for patients undergoing bowel resection had been within the expected ranges for 2014 and 2015 as had the 90 day readmission rates. Temporary stoma rate for the trust was higher than expected. The trust had 188 operations and a case ascertainment rate of 120% which was good when compared to other hospitals.
- In the 2015 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 5.3%. This placed the trust within the middle 50% of all trusts for this measure. The 90-day post-operative mortality rate was 3.8%, within the expected range. The 2014 rate was 4.9%. The proportion of patients treated with curative intent in the Strategic Clinical Network was 36.7%, in line with the national aggregate. This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results
- When comparing the 2014, 2015 and 2016 National Emergency Laparotomy Audit (NELA) there had been improvements made year on year. Of the six measures the trust performed better than the national average for three of them. These included appropriate

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documentation, access to theatres, and for mortality rate. The trust performed significantly worse than the national average for the percentage of operations where a consultant anaesthetist and surgeon present. The national average was 74% of operations with the trust only achieving this in 35% of operations. Improvements were being made and as a result of the NELA audit results the introduction of 'boarding cards' has improved communication between teams and facilitated timely transfer the appropriate pathways

- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, the two indicators relating to Groin Hernia showed more patients' health improving and fewer patients' health worsening than the England averages. No other outcome data was provided by the trust.
- Emergency re-admission rates were low with the only 1.75% of patients returning to hospital between April 2016 and August 2016. This is improved from 2.82% of patients returning to hospital between April 2015 and March 2016.

Competent staff

- Between April 2015 and March 2016, 77% of staff within surgical services had received an appraisal compared to a trust target of 85%. Medical staff had a completion rate of 72%, nursing staff had a completion rate of 86%, nurses banded two to four had a completion rate of 85%, allied health professionals had a completion rate of 78% and all other staff had a completion rate of 66%.
- Staff had the right qualifications, skills and knowledge and experience to do their jobs. There were clear competency frameworks training plans for staff working on the wards. We saw a training matrix for one of the wards which clearly demonstrated the essential training specific to roles and who had completed it. Training included venepuncture, cannulation, catheterisation, medical gasses, and tissue viability. There was a clear competency process for nurses working in Queens Day Unit to ensure suitable levels of knowledge and skills to ensure safe recovery of a patient post procedure. This included the preparation, understanding of procedures, handover, and risk assessments as well as a reflective piece of work which was signed by an assessor. There were also clear preceptorship and induction processes in place which had clear aims and objectives which needed to be signed off by an assessor before being deemed competent.

- The trust had an effective staff induction programme. We saw a two day induction programme for new nurses called the Adult nurse - ward survival guide. The itinerary covered topics such as infection control, sepsis 6 pathway, blood glucose testing, risk assessments and incident reporting. We spoke with a staff nurse who had been in post for a year and we were told the trust had provided an induction programme and four weeks supernumerary and the nurse told us this had been sufficient a period of time. We spoke with a newly appointed staff nurse in theatres and we told the induction to the unit was at that time going well. The nurse was given a work book and was visited weekly by the practice facilitator to check on progress. As the nurse had not been theatre trained, they were offered a three month supernumerary period. Another newly qualified nurse said additional training provided was good and ensured they were trained to manage tasks on the ward such as cannulation and wound dressing.
- The surgical directorate had employed a practice education nurse facilitator. This role encompassed working across all of the wards to support newly qualified and new staff to the trust. The role had a dual purpose, to increase ward competence and support managers with the compliance of their team's essential training. This individual also spent time with all nurses in their preceptorship and acts as a mentor. They also spend a shift with them to observe their practice and give constructive feedback on how they could improve.
- However, we spoke with one first year doctor who said they felt limited in what work they were doing. We were told there was limited additional training post-graduation and the scope of practice for doctors was limited.

Multidisciplinary working

- All necessary staff, including those from different teams and services were involved in the assessing, planning and delivery of patients care and treatment. Board rounds were held on a daily basis and involved the medical, nursing and therapies staff. These managed the ongoing risks around patient care and discussed ongoing discharge as a team. Within this discussion current condition (such as falls, pressure ulcer risk, and cognition) were discussed and actions planned for care. We found these discussions were meaningful and inclusive of all staff. We found actions were clear and

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everyone left these meetings knowing what actions needed completing. Another example was the inclusion of a thoracic consultant in a patient handover from the emergency department to the ward.

- Staff on the cardiac wards were positive about access to additional services. For example, tissue viability services were available on the same day as referral improving the outcome of the patients. We were also told specialist nurses can attend the ward quickly when required, particularly for upper and lower gastrointestinal care.
- The service ensured arrangements for discharge were considered prior to elective surgery taking place. We found discharge was discussed with patients on admission onto the wards and updated on a daily basis during the ward handovers. However, we found discharge was being hampered by issues within the wider health system. In October 2016 there were four new delayed patients equalling 56 delayed bed days with the reasons being social care funding issues, social care assessment delays, and waiting for a community rehabilitation bed.
- When people are discharged from the service this was done at an appropriate time of day and was only done when ongoing care was in place. Between April 2016 and August 2016, 30% of patients were discharged between 7am and 12 noon and only 3% of patients were discharged out of hours. Only 12% of patients were discharged to the discharge lounge, the remaining patients were discharged either to their home or to an ongoing place of care. The trust recognised performance on this measure had remained consistent and additional actions, such as deep dives into patient discharges and exploring an additional target of 'before 4pm' could be introduced to allow the trust better insight into the data.
- Technology was being used to improve the effectiveness of the multidisciplinary team decision making process. Video clinics were being held so doctors could remotely be part of the process at other acute hospitals.

Seven-day services

- Services were provided out of hours and weekends and this included pharmacy, physiotherapy and imaging services. Out of hours access to a pharmacist was managed by an on call system and staff we spoke with reported this system worked well.

- Consultant, registrar, senior house officers (doctors employed full time at the trust who are not undertaking further education) and junior doctor cover was provided 24 hours a day seven days a week.
- For trauma and orthopaedics consultants were onsite between 8am and 8pm daily (to attend the 8am trauma meeting, perform ward rounds, clinics, administration, and trauma lists as per job plans) with on-call consultant cover provided between 8pm and 8am. Additional consultant ward rounds were conducted in accordance with individual job plans. Registrars were onsite between 8am and 8pm to attend the 8am trauma meeting, ward rounds, clinics, and to assist with trauma lists. These doctors held the on-call bleep and there was the possibility they could be called to the emergency departments or onto wards. Between 8pm and 8am registrars were on call and contactable via the on call bleep. Between 8am and 8pm senior house officer doctors were available between 8am and 8pm and attended the ward round then be on call for the emergency department, the surgical and trauma assessment unit and for the surgical wards. Between 8pm and 9am senior house officers were on call for the whole site and at weekends would be allocated to wards on each day.
- For thoracic surgery, consultants were on site between 8am and 8pm and on call from home between 8pm and 8am. During the day workload involved clinics and elective surgical lists with emergency surgical work being covered as necessary. All available consultants, as well as on-call consultants, would do a morning ward round every day, including weekends. Registrar and junior doctor cover was managed separately by cardiothoracic specialist services.
- For ear, nose and throat consultants were available between 8am and 8pm and ran a rota being on call a week at a time. Consultants were not on site at weekend but were available on call as required. Registrars worked on site between 8am and 8pm and were available on call between 5pm and 8am. However, these doctors provided cover to four acute trusts in the region. At weekends a registrar was on call between 9am and 1pm with a second registrar being contactable at the first registrar's instruction. Senior house offers were onsite working 12 hour shifts 24 hours a day seven days a week.
- For anaesthesia consultants were on site between 8am and 6pm Monday to Friday with a trauma consultant

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and an aesthetic ophthalmic consultant between 8am and 6pm on Saturdays and Sundays. Specialty doctors were available on call for anaesthetic emergency cover 24 hours a day seven days a week.

- For general surgery consultants were on site between 8am and 6pm with on call from home overnight. Additional consultants were on site to ensure ward rounds were completed. There were specialist doctors on call 24 hours a day seven days a week with additional consultant on call cover for oesophagogastric and hepatobiliary patients.
- For cardiac cover junior, registrar, fellow, and senior house officer doctors were on site 24 hours a day seven days a week and operated daily. Cardiac surgery, cardiac anaesthesia and intensive care consultants were on site daily and available on call overnight. All consultants on call needed to live within 30 minutes to ensure emergency cover was available.

Access to information

- All information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way including access to risk assessments, care plans, case notes and test results. This access was maintained when transferring patients between services. For example, we saw examples of effective handover between the emergency department and wards.
- We saw discharges were coordinated in line with the Nation Institute of Clinical Excellence Quality Standard 15 Statement 12 in that patients experienced care between services in a coordinated way. We looked at several discharge summaries and found they were complete and comprehensive.
- Where necessary patients who attended the pre-admission clinic (PAC) were given leaflets on smoking cessation, weight management and alcohol intake. Patients whose planned operations required an admission to the high dependency or intensive care unit were given information leaflets about these areas and were offered a chance to visit the department prior to their admission. Other leaflets that were available during the PAC explained the discharge lounge, pressure ulcer prevention and venous thrombus embolism prevention.
- The Summary Care Record (SCR) is a secure national electronic record, which is a programme dedicated to using technology to support better information sharing

between local health and social care organisations. Staff at the PAC could access this record called Connecting Care, which enabled them to have information on for example, any medications, allergies, recent appointments and diagnoses that a patient may have had. This record was also available for GPs to access and allowed information to be shared quickly and safely.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent was sought. Patients we met all said they had signed consent forms following a discussion with the doctor. They had been given the opportunity to ask questions and told the advantages and risks of the process they were about to undergo. For some procedures, such as taking blood samples or general tests, specific written consent was not required. However, patients would be required to give implied or verbal consent. Those patients we asked said they were always asked for their permission by staff before any procedure.
- The trust reported that Mental Capacity Act and Deprivation of Liberty Safeguards training was fully incorporated into safeguarding training undertaken by staff. Staff we spoke with understood the relevant consent and decision making requirements of legislation and guidance including the Mental Capacity Act 2005. Staff could give us examples of when the act would be used and in what capacity and the processes

Are surgery services caring?

Outstanding



We rated caring as outstanding because:

- We spoke with 30 patients during this inspection on all of the wards and theatres we visited. We also received large numbers of comment cards about the service. Feedback from patients and those close to them were continually very positive about the way staff treated people with no negative comments. We were given multiple examples where staff had gone the extra mile and where care received exceeded patient's expectations. People were always treated with privacy, dignity, respect and kindness.

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- Comments made were consistently positive and supportive towards patient centred care. There was a strong patient centred culture and relationships between staff, patients, and their relatives were strong, caring and supportive.
- Friends and Family test results in the surgical division were better than the rest of the trust and had a higher response rate than the England average.
- People were involved as partners in their care and were supported with making decisions. We were given examples where relatives and carers were included as part of the care provided for both physical and emotional wellbeing. We received a plethora of examples where carers and relatives were involved in patient care and where emotional support had been given. People's individual preferences were reflected in how care was delivered.
- People's emotional and social needs were valued by staff and were embedded in their care and treatment. We were given multiple examples where emotional support was provided which had a positive impact on the patients' health and wellbeing.

Compassionate care

- We found staff took the time to interact with people who use the service and those close to them in a respectful and considerate manner. We observed examples of care where this was taking place which had a positive impact on the patient. One example of this was when two surgeons went to the discharge lounge to say goodbye to a patient and to answer any final questions they had. We observed this to be good support for the patient and put them at ease for their onward journey from hospital. Patients on wards we spoke with were consistently positive about how staff interacted with them. One patient said "I would be happy for any one of my family to be treated on this ward", another said "the staff have been brilliant and very caring. I have no complaints at all".
- Patients we spoke with said they made sure people's privacy and dignity were always respected, including during physical or intimate care. We spoke with six patients in the discharge lounge who were consistently complimentary about the care they received. They all said they were treated with privacy and dignity during their entire stay at the hospital. One patient we spoke with said "I have been treated really well by all. I was always treated with dignity, compassion and respect",

another said "staff have been really good to me. I have been treated with privacy, dignity and respect". When we were on the surgical wards we saw good examples of care which respected people's privacy and dignity. When physical or intimate care was required curtains were always fully closed to ensure privacy and when staff either entered or left the bay or room they always ensure they done so carefully so as not to compromise privacy. In theatres we saw that at all times patients dignity was preserved by making sure patients were covered up during their procedure. When patients arrived in theatre they were warmly welcomed by the staff who were attentive to their needs. We saw examples of staff making meaningful conversation with patients and putting them at ease. One patient told us they felt they were well respected by staff. We were given an example of how they got to know her better upheld their personal preference to have female staff helping them get changed. Patients on wards said "the staff have been excellent. I am in here quite a lot and the staff know me really well" another said "I have been treated really well by everyone on the ward".

- The Friends and Family Test (FFT) is a nationally recognised tool used to help service providers and commissioners understand if their patients are happy with the service provided, or where improvement is needed. FFT response rates for the Surgical Head & Neck division were 39% which was better than the England average of 29% between September 2015 and August 2016. Response rates for the Bristol Royal Infirmary were 43%. The average score for the division was 97.5% which was better than the rest of the trust. Additionally to this assessment staff were asked to complete a patient survey which was analysed on a monthly basis based on patient experience and kindness and understanding. The division consistently performed very well when comparing the patient experience in surgery with the rest of the trust". The trust participated in Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE). The assessments involved local people known as patient assessors, assessing how the environment supported the provision of clinical care. The trust scored above the national England average for privacy, dignity and wellbeing.
- We found during the inspection call bells were always responded to quickly on the wards regardless of how busy they were. One patient we spoke with said "when I used the call bell nurses came really quickly to manage

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my pain. I was treated really well in that regard". Other patients were positive about how quickly pain was managed on the wards saying they always quickly received medication when they asked for it to make them feel comfortable. However, one patient we spoke with on a ward said on one occasion they had to wait ten minutes for their call bell to be answered. We observed examples of staff responding well to patients in distress. One example was with a patient who was using a walking stick to get out of the ward upon discharge. A student nurse saw this, recognised they were finding walking difficult, and asked if they wanted a wheelchair, they then escorted them to the discharge lounge.

- There were limited opportunity in the wards to make hospital feel 'normal' to patients. There was no access to day rooms which meant patients had to either eat in bed or in their chairs. Although patients we spoke with said they understood this and felt well informed as to the reasons why. Dietary requirements were also explained well as described by one patient who said "I am on a liquid diet because of my operation but had this explained to me well. It isn't an ideal situation but I am being helped through it". Another patient said "I am on a restrictive diet but myself and my family have been informed as to why this is happening and how long it will be for". Staff on wards were given protected time to help with meal times. We saw good practice where staff were helping patient to eat their meals and sat with them during this.
- In the surgical trauma assessment unit there was a seated area with eight chairs and one cubicle. This cubicle had a curtain across to ensure dignity was preserved. We found that despite the curtain conversations between staff and patients could be overheard which compromised confidentiality. For example we heard a patient in distress who has having blood tests taken which was making the patients in the seated area feel uncomfortable. One patient we spoke with said "this is a bit impersonal being able to hear others conversations".

Understanding and involvement of patients and those close to them

- Staff communicated with people so they understood their care, treatment or condition. Patient we spoke with said they were informed about their care and that their relatives were included in discussions. One patient said

"they always keep me informed about the care I receive". Another patient described their disabled spouse was not able to visit regularly so had daily phone calls with the staff to ensure they had an update on the patients care. A patient said "this has gone a long way to making my partner feel better during this worrying time".

Another patient described how they were making adjustments to ensure their blind sister was informed of their care throughout their visit. The patient said they were relieved and happy they were being informed.

- Staff we spoke with gave us examples of when they had to deliver bad news to a patient and ensured this was done in a confidential environment giving them as much time as necessary to ask questions. We also saw an example in theatres of staff having a discussion about how they were going to make adjustments to communicate with someone who had their operation cancelled due to anxiety to ensure they supported the patient as much as possible during their care and treatment.

Emotional support

- Staff understood the impact person centred care had on the wellbeing of the patient and those close to them both emotionally and socially. We were given multiple examples of how care had been given in ways to alleviate anxieties and concerns. We observed on multiple occasions on wards where care had been delivered in a way which supported positive wellbeing both in hospital and for their onward journey out of hospital. For example, discussions about discharge were given in a supportive and reassuring way, and where there had been delays in discharge patients were given time with nurses to discuss concerns and worries. Staff could describe the importance of offering emotional support and could give examples of the positive impact it had on patients. Patients we spoke with on the wards all reported how they had been supported emotionally during their inpatient stay. One patient told us he "has had an exceptional experience" and told us of a specific nurse who was particularly good and "got him through the first three days".
- Patients and their relatives and carers were given timely support and information to cope emotionally with their care, treatment or condition. We were given an example of good patient care where they were given a tour of the intensive care unit prior to their operation so they knew the environment they will be in better. This relieved

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anxieties of both the patient and their relative who attended this. Another example we saw in theatres where a patient was anxious about their operation. The nurses rang the patient and supported appropriately to attend and successfully have her operation.

- People were enabled to have contact with those close to them and to link with social networks or communities in a variety of ways. All patients were given access to Wi-Fi to enable them to access the internet and were given opportunities to use telephones to contact friends, relatives or carers. We also found although visiting times were set to ensure uninterrupted periods of the day and night they could be flexed to meet the needs of the patients or their relatives. One patient we spoke with described how their anxiety was reduced as their partner was allowed to stay later in the evening when they had their operation.

Are surgery services responsive?

Good



We rated responsive as good because:

- Services are planned and delivered in a way that meets the needs of the local population. The importance of flexibility, choice and continuity of care is reflected in the services. Care and treatment was coordinated with other services and other providers. However, sometimes incurred delays due to issues elsewhere.
- People could generally access the right care at the right time. Access to care is managed to take account of people's needs, including those with urgent needs. RTT standards were being met 92% of the time. Where there had been a slip in performance there were clear actions to address these which had been proven to be effective.
- Although slightly limited, reasonable adjustments were made for people living with dementia or with learning difficulties including use of the 'this is me' document and access to activities for stimulation. There were access to dedicated teams for dementia, learning disabilities and psychology which were always available. Patients we spoke with were mostly happy with the attentiveness of the staff allowing their needs to be met.
- Waiting times, delays and cancellations were minimal and managed well.

However:

- We found due to flow issues some specialties were not seeing patients in an appropriate time frame. For example, not all endoscopy patients were seen within 7 days of referral, only 77% of cleft palate patients had their surgery within the national standard, and 89% of dental patients were seen within the national standard.

Service planning and delivery to meet the needs of local people

- We found at the time of the inspection there were very few surgical outliers and historically was regularly performing better than the trusts surgical outlier targets. In July 2016 there were a total of 199 bed days spent outlying which was slightly worse than a 190 bed days target. In July 2016 other divisions spent 285 bed days outlying in surgical areas, with 256 of these being medical patients. The site team actively allowed surgical patients to outlie to The Bristol Eye Hospital, escalation wards, Queens Day Unit, and the physiotherapy gym to allow medical outliers to remain on the main hospital site as their consultants were not able to accommodate review elsewhere.
- Recovery and Day Surgery areas were not used as often to accommodate patients overnight as they were during the last inspection. Between September 2015 and August 2016 the recovery area had been used 75 times, and the day surgery area had been used 161 times. Staff we spoke with in recovery said that it was regularly used but for no more than two patients. The trust had a number of mechanisms in place to mitigate against the use of these areas overnight and a system of patient flow management with reviews of capacity, demand and Trust/system escalation at four scheduled meetings each day. These were supported by clear actions and escalation triggers set out in the Trust's Adult Escalation and Extreme Escalation Policies. The vast majority of use of recovery overnight was for patients requiring high dependency unit care, where surgery had proceeded on the basis of bed availability that later reduced due to unexpected circumstances. This then had an impact on the following day's elective surgery capacity.
- Theatre utilisation at Bristol Royal Infirmary ranged from 58.3% to 91.8% during the period May 2016 to July 2016. When we discussed this with managers there were clear and reasonable reasons as to why theatres were not being used and we found they were being utilised fully with the staffing and bed base available.

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Access and flow

- Most people had timely access to initial assessment, diagnosis and urgent treatment. Referral to Treatment (RTT) timeliness was monitored on a weekly basis in the Surgical, Head & Neck division which was reported to the trust board on a monthly basis. Each subspecialty within the directorate reported to a RTT lead who held them to account for actions against an action plan and discussed individual patients who were waiting longer than 18 weeks with consultants to ensure the patients at highest risk were seen first. Between September 2015 and August 2016 the trust had continually been above the England average for RTT times. Overall the RTT standards were met 92% of the time in October 2016. Where there had been a slip in performance there were clear actions to address these which had been proven to be effective. For example, in dental services in October 2016 the RTT standard was met only 89% of the time due to staffing issues. This was recognised by the trust and more than ten dentists had been employed by the service and were due to start shortly after the inspection. Another example was in the Cleft service which, due to one member of staff leaving, had a performance rate of 77%. This was recognised by the trust and work was being done to upskill clinical nurse specialists to ensure the standard was met.
- There were continual capacity issues in Endoscopy resulting in many patients not being seen within 7 days of referral. Despite having a waiting list a recovery plan has been verified by JAG (Joint Advisory Group) and the trust maintained accreditation. Although performance had been gradually improving only 72% of patients were being seen within the timeframe (against a standard of 90%) which had affected the trusts ability to oblige to two week cancer wait standards. There was a shortfall of 5.3 lists per week on endoscopy with a significant backlog. The division has been training an endoscopy nurse practitioner to increase capacity and by outsourcing to another provider which was working long term with the trust to reduce the backlog and manage ongoing capacity issues. It was noted in an action plan there was a significant element of patient choice with patients not being able to attend within seven days of referral. Diagnostic six week waits in Endoscopy with performance being a little short of 99% which was also due to limited capacity in the unit.
- The cancer waiting list was well managed in the Surgical Head & Neck division. The trust was on average meeting the 96% standard for 31 day diagnosis to first definitive treatment cancer pathways. In July 2016 there were three breaches, none of which were fully attributable to the hospital. For 62 day urgent referral to treatment time standard the trust performance was mixed. In July 2016 performance was 73.3% and August 2016 performance was 84.8%. In September 2016 only eight patients breached the standard with a majority of these being unavoidable due to patient choice.
- Care and treatment was cancelled or delayed only when absolutely necessary. Between July 2014 and June 2016 cancelled operations for elective admissions remained slightly higher than the national average, but remained consistently between 0.8-1.3% of patients. In July 2016 35 out of 2,498 procedures were cancelled on the day, totalling 1.4% of patients against a 0.8% target. Out of these 12 were cancelled due to no ward beds being available and six were cancelled due to intensive care unit/ high dependency unit beds being available. Four patients were cancelled due to other clinically urgent patients being prioritised, four due to late starts or lists over-running, five due to the surgeon or anaesthetist not being available, two were due to equipment failure and one was due to an administration error. An action plan recognised the division had experienced continuing pressures due high emergency take and long periods with lots of medical outliers on wards. There were also some periods of time where acuity in the Intensive Care Unit caused elective cancellations. People were supported to access care and treatment again within 28 days as far as possible. For the period of April 2016 to June 2016, very small numbers of patients were not treated within 28 days. For example, in July 2016 only two patients did not get rebooked within 28 days.
- During our inspection, we saw how efficiently the emergency theatre worked with the wards to identify the golden patient. This was a pre-selected patient who was allocated first on the morning's theatre list who had a clear surgical plan in place and had already been reviewed by the anaesthetist. This enabled the case to start on time as all members of the team including the ward staff were ready on time. Theatre staff told us how this had improved operation start times and started the theatre day smoothly and efficiently.

Meeting people's individual needs

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- We found some reasonable adjustments were made to take into account the needs of different people on the grounds of religion, disability, gender, or preference.
- Most people were satisfied with the quality of the food provided. Of the six patients we discussed this with one said the food could be improved. One patient said “the food was hit and miss and I put it down to the fact I didn’t always receive his menu to choose my food”. On the wards all of the patients we spoke with about food were consistently positive about the variety and the quantity of food available. One patient said “they were always offered more food when they finished their meal”. We spoke with one patient who was complimentary about the service because they were able to provide them with Halal food. Staff we spoke with said regardless of logistical challenges which may come with respecting religious needs they would always ensure these needs were met. Some staff we spoke with gave us examples of the types of adjustments they would make for different religions or beliefs showing understanding of the different patient needs. Services were planned in such a way which ensured patients in the discharge lounge received ample food and drink during their stay in this area. One patient we spoke with said they had been in the lounge all day waiting for transport and was regularly offered food and drink.
- There were mixed levels of satisfaction from patients with regards to access to facilities. One patient we spoke with said they were given access to the internet, a television, a radio and were offered newspapers on a daily basis. One patient said “what impressed me the most was the fact that every staff member at every level made his stay as comfortable as it can be”. However, one patient said they brought puzzles in with them for their stay but was never offered them by the staff.
- We found reasonable adjustments were made so disabled people could access and use services on an equal basis to others. Staff we spoke with discussed how they would change the way they communicated with patients depending on their disability. For patients living with a hearing impairment they were able to use to white boards to allow them to communicate better and could access information in brail for patients with a visual impairment. We spoke with one patient who was living with a speech and language impairment who was satisfied with the care and the adjustments made to allow him to communicate with staff.
- There were suitable arrangements in place for people who needed translation services. Nurses we spoke with described how they would use a telephone service if they needed a translator. This phone service was available 24 hours a day seven days a week. Staff described why they would not use a member of a patient’s family to translate for them as there was a risk of mistranslation or misrepresentation of the information. We were given an example of where an interpreter attended an appointment between due to the sensitive nature of a conversation. Staff described how it was not appropriate to have such a delicate conversation using the phone line. However, we found there were a limited selection of leaflets in foreign languages available on the wards. In some areas, such as the discharge lounge we found no leaflets at all in any language other than English.
- We found there were some suitable arrangements in place for people with a learning disability. Discussions between the doctors, nurses and outside providers (such as GP) were held prior to elective admission and information about learning disabilities was transferred well between areas of the hospital. Hospital passports were used as part of the admission process to rate the level of impairment and the support required. This document went with them throughout their visit to hospital. Additional support was available through the Learning Disabilities Liaison Nursing Team. However, this team was small and was only available during weekdays.
- We found the service was designed in a way to care for people with complex needs when they got to hospital. For example, all areas of the wards and theatres were accessible by wheelchairs with ample space for disabled visitors to be at a patient’s bedside. There was also clear signage and an information point to help patients get to where they needed to go. However, there was limited parking for disabled patients which made access difficult. The trust’s website encouraged people to use public transport to get to the hospital which may not be ideal for patients with complex needs although drop off points was available with access to wheelchairs at the entrances to the hospitals.
- Training in managing people living with dementia was embedded into the adults safeguarding training. Staff we spoke with on the wards had a clear understanding of the adjustments they needed to make to manage patients living with dementia. All patients diagnosed

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with dementia or had cognitive impairment had a 'this is me' document produced when they were admitted. This allowed staff to understand what the patient's likes and dislikes were. Patients living with dementia had a forget-me-not flower above their bed and on the ward's white board so people coming into the ward knew of their impairment without looking in the notes.

- The Commissioning for Quality and Innovation (CQUIN) framework contained a national goal for improving dementia care promoting the identification of patients living with dementia and other cognitive impairment, to prompt referral and then follow up after they leave hospital. The hospital audited against this and performed better than the target for all questions on identification, assessment, and referral and follow up between April 2016 and August 2016.
- The Bright Ideas Project was a multidisciplinary project to improve the experiences of patients in hospital living with cognitive impairment. This group developed a questionnaire and reported on the experiences of 46 patients and their relatives. From this group an action plan was developed to introduce therapeutic activities for patients on wards. We found some adjustments had been made for people living with dementia. We saw on some of the wards we visited there was an activities cupboard with a range of puzzles, books, and games. Staff told us they would often sit with patients and do these activities with them and found it had a positive effect on the patients' wellbeing.
- Psychiatric support was available for all patients on wards between the ages of 18 and 64 and was accessible through a referral process. The service offered included medication advice, helping people cope with the psychological effects of their physical health problems, medically unexplained symptoms, support and advice regarding anxiety or mood disorders, anxiety management and relaxation techniques and was available seven days a week.

Learning from complaints and concerns

- People we spoke with knew how to make a complaint. Of the patients we spoke with many said they would be happy to raise concerns with staff and could make a complaint if they wanted to. One patient we spoke with said they felt enabled and "confident to speak up" if something happened that they didn't like. Many patients went on to say they had nothing they would

wish to raise a complaint or concern about due to the good quality of care. There were information leaflets available for complaints in different languages, although these were only available on request.

- We found posters were on the wards to invite people to raise concerns or issues with members of staff or through the trusts complaints team which were available via email, telephone, or by post. The service also offered a 'drop in' session for patients and visitors to raise concerns directly with the team five days a week.
- The NHS constitution gives people the right to have complaints dealt with effectively, be investigated, and to know the outcome of an investigation. We looked at a selection of complaints and found they were managed in a compassionate and caring way. The outcome was explained and a sincere apology was given.
- There were a total of 75 complaints between February 2016 and August 2016. The hospital took an average of 32 days to investigate and close these complaints. Timescale for resolution of complaints were agreed as part of individual resolution plan based on the complexity of the complaint rather than by a set date. Timescales for these individual resolution plans were met 95% of the time within the division and 90% of the time when the trust executive team was involved (for the most complex of complaints).
- Lessons of complaints were shared with staff at safety briefings and through newsletters. Staff could give us examples of where they had changed practice as a result of learning from complaints not only on their ward or theatre but in the wider trust.

Are surgery services well-led?

Outstanding



We rated well-led as outstanding because:

- The strategy and supporting objectives were stretching, challenging and innovative whilst remaining achievable. The strategy for the surgical division was detailed and set out clear objectives for each of the service lines.
- Governance and performance management arrangements were proactively reviewed and reflect best practice.

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- Leaders have an inspiring shared purpose, strive to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.
- There were high levels of staff satisfaction across all equality groups. Staff were proud of the organisation as a place to work and spoke highly of the culture. There are consistently high levels of constructive engagement with staff. Where there had been a poor culture identified innovate and effective actions were put into place to resolve them.
- Innovation was actively encouraged throughout the surgical division from staff led forums to improve the efficiency of work streams to research in pioneering research techniques. All changes were monitored effectively to evidence the improvements to patient care the changes had.
- There had been clear improvement since the last inspection in September 2014. All requirement notices which were issued that time had been managed appropriately.

Vision and strategy for this service

- There was a clear mission statement, vision, and a set of values with quality and safety the top priority which were developed in partnership with staff working in all of the hospitals in the trust. Staff were clear as to what the vision was and worked in line with the values.
- There was a realistic strategy for achieving priorities and delivering good quality care. A divisional operating plan for 2016/17 and 2017/18 highlighted the trusts strategic objectives broken down into ten divisional objectives, actions required to complete the objectives, and how they were going to complete them. Examples of this included the trust objective to “continually deliver high quality individual care, delivered with compassion” was broken down into five divisional objectives which included “improve the care for patients presenting with fractured neck of femurs” and highlighted the need of a comprehensive review of the service with wider health partners. Similarly to this was a set of transformation priorities which were to be integrated into divisional business plans, health and safety priorities and quality priorities with each element having actions and timescales to complete them.
- Senior staff were clear in their understanding of the strategy, their role in achieving it, and were enthusiastic about delivering it. All managers we spoke with were

aware of the strategy for the service, their involvement in transformation, and the importance on delivering quality to patients. Staff had progress on the divisional objectives shared within the ‘Cutting Edge’ newsletter which was released quarterly.

- The positive attitude and commitment to the trusts vision and values was evident with all of the staff we spoke with across the surgical directorate. Staff in theatres were positive, enthusiastic and forward thinking, and told us they were committed to delivering the best care. It was clear the department embraced change, which was apparent with the new technology being trialled at the time of our inspection.

Governance, risk management and quality measurement

- There was an effective governance framework which supported the delivery of the strategy and good quality care. The Surgery Head & Neck division was managed by a clinical chair, divisional director, a head of nursing, a deputy divisional director and a deputy clinical chair. The division was split into eight service lines (anaesthetics, dental, Ear Nose and Throat & Thoracic, Eye, Gastrointestinal, Intensive care, Theatres, and Trauma and Orthopaedics) which were managed by a clinical director, a matron, and a service line manager. All management staff we spoke with were clear about their roles and understood what they were accountable for.
- The governance frameworks and management systems were regularly reviewed and improved. A rolling programme called the ‘governance assurance review’ looked at the effectiveness of governance processes in place within each of the eight service lines every four months. The divisional management and the patient safety teams used this to seek assurance that areas of improvement are being identified and addressed. This was then rated and recommendations made.
- The trust held the divisional managers to account on a monthly basis. Senior managers within the division said they were challenged fiercely around quality and risk management, but were also well supported and given resources when necessary to perform improve. Divisional meetings were held on a weekly basis where the divisional managers would hold the service line managers to account for the quality and safety of the care being delivered. Information would then be disseminated down to local teams. Team leaders we

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spoke with were positive about the divisional governance meetings and one member of staff said they were impressed by the divisions “willingness to try and improve”.

- Locally team meetings were held on a monthly basis where messages were disseminated. Staff discussed these as a forum to raise issues as well as listen and took a lot from them. At the end of each shift handover the teams had a ‘safety brief’ to ensure that lessons from incidents were shared. This included local learning, learning between wards, and learning for the whole trust known as ‘trust messages’ which included ward messages (such as learning around discharge planning), divisional messages (such as three point identification checks), and trust messages (such as disposal of confidential information). Staff in theatres were positive about how these meetings were conducted and felt they always learnt something from them. However, we found in the surgical trauma assessment unit this felt rushed and not all staff were listening to what was being said.
- There were comprehensive assurance systems and service performance measures which were reported and monitored on a regular basis. Action was taken to improve performance. The division held a dashboard to gain oversight of performance measures for quality, flow, and workforce which fed into divisional governance meetings. Where standards were slipping action plans were immediately put in place to resolve them. Information around actions were disseminated to staff through staff meetings, safety briefings, and written leaflets and posters. Risk registers were held in each of the service lines and anything rated under a twelve was managed locally. Action plans were created for these risks with accountable individuals, and timelines for resolution. We were told the divisional managers provided high challenge and support to encourage local teams to improve quality.
- There were 11 risks rated 12 or above on the divisional risk register. The highest risk scored a 15 and was around meeting cancer standards. This risk was reviewed weekly at a divisional level and weekly at a trust level to ensure oversight of the ongoing actions to resolve the issues. The remaining ten risks were rated 12 with themes around referral to treatment standards, staffing, financial cost, and quality of care. Each had rigorous controls in place and were regularly monitored.
- Leaders had the skills, knowledge, experience and integrity they needed to lead the service effectively. All leaders we spoke with, at both ward and divisional level understood and carried out their responsibilities well and had a clear understanding of their own work and the work of others around them.
- Leaders were visible, approachable, and encouraged appreciative and supportive relationships amongst staff. All team leaders we spoke with commented on the positive relationship they had with divisional leaders despite them being new into position. We were told they listen to concerns and worries and had a “good style of managing”. Others said they were supportive, focused on staff and one member of staff said they were a “breath of fresh air”. Team leaders appreciated the opportunity to meet with them on a weekly basis and by having monthly one to one sessions to discuss personal development and concerns. Staff told us the trust team were approachable and were always “caring towards their staff”. One member of staff gave an example of when they were called up by the chief nurse at seven in the evening on a Friday to discuss a traumatic situation which occurred that day.
- At a ward and theatre level staff were equally as complimentary about the sisters and managers. Everyone we spoke with said they were well supported by their managers and could go to them with any concerns. We were given examples of where managers had listened to staff and acted upon concerns swiftly and effectively. Staff described the matrons as “brilliant and supportive” and were available whenever needed.
- Doctors we spoke with were complimentary about their leaders. We were told they were proactive and felt appreciated by them.
- We saw evidence of recognition schemes for staff excellence. All staff were encouraged to nominate individuals. The divisional managers gave awards in recognition and appreciation of the teamwork and commitment to patient services they display.
- Staff we spoke with could identify their divisional leaders. Photographs of the senior management team for the directorate were clearly displayed in ward areas and staff nurses and health care support workers we approached knew who their senior management team were.

Leadership of service

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- We saw how proactive and forward thinking senior leadership in the theatre departments had become. New technology was being trialled at the time of our inspection with the overarching aim of streamlining services across the trust.

Culture within the service

- The attitude across all the departments in the surgical directorate was overwhelmingly positive. We saw how engaged senior members of the team from the clinicians to matrons were with the department staff to ensure they felt respected and valued. Senior staff clearly cared what their teams were feeling and actively encouraged collaborative working to improve the service; this was evidenced by the trial in Hey Groves theatres of the Happy App. We were shown an example of how well this worked when a team member had added an idea and was encouraged to develop it; this resulted in a new stock checklist for the theatre department and the sterile services unit.
- Staff reported how a positive culture change in main theatres gave them the confidence to speak out without concerns. Staff reported they were 'being listened to'.
- Staff were open to challenge and actively challenged others on the quality of their work. One example was when a nurse challenged the quality of patient notes when transferring a patient from one ward to another.
- There was engagement from all levels of staff within the operating suites to the World Health Organisations (WHO) surgical safety checklist.

Public and staff engagement

- Outside of ward areas there were posters which displayed "you said, we did". These were comments left from patients which resulted in a change in the ward. For example, one patient commented about the temperature of the ward, this was resolved by introducing air conditioning. Another example was when a patient raised there was no clear communication from the staff, so changes were made to the multidisciplinary team process to improve communication.
- Friends and family results were displayed across the departments of the hospital and we observed during the pre-admission process all patients received a comments card.
- There was a strong emphasis on promoting the safety and wellbeing of staff. The trust held a theatre quality

and culture week to support staff to deliver high quality care. During this time 37 different theatre liaison officers (staff with management experience but from outside of the directorate) spent four days supporting 32 theatres. A fifth day was spent giving immediate feedback and discussion points for teams and managers. The feedback and data were collated and themes shared with the teams at the end of the week event. These were then taken to the Transformation project steering group meeting to enable the theatre management team to agree and plan actions going forward. Key themes included the operating theatre profile rising in a positive light, with a greater understanding of theatre process and challenge from everyone and a greater sense of connection between management team and theatre staff team.

- The trust had introduced a programme of work called 'Happy App' into various areas of the surgical division. This was a tablet based programme, which engaged staff in regular real time feedback. This allowed staff to express whether they were feeling positive or negative about their work and the reasons behind them anonymously. This enabled the trust to respond to these issues in real time and avert potential problems as well as sharing positive emotions and comments. On two surgical wards on 9 August 2016 there was a total of 75 comments placed onto the " with 31 of these being positive, 20 being neutral, and 24 being negative. A report was created on the same day which acknowledged the good comments (some of these being "brilliant team work within staff, good atmosphere and good vibes" and "the team have all worked together") and recognised and acted upon negative comments. For example one comment was "not enough staff to manage the number of confused and venerable patients" which was responded with "please make sure all have their enhanced observation risk assessments completed so we can request additional staff if required. Should dependency outweigh skill mix please talk to me or on call matron to see if anyone can help us". This ensured a quick response to the issue and supported staff to act upon these concerns. The trust engaged with staff to get their views on the programme and some of the comments included "already seeing changes from the comments made each week" and "I feel that being able to report, our issues are being listened to which is positive in itself". Managers explained to inspectors there had been a correlation between an increase in

Surgery

incident reporting and the use of the 'Happy App'. A report stated "rapid changes in mood in a department highlighted on the app may act as a smoke detector for problems arising indicating that this may then provide an impetus for early intervention".

- Senior staff had identified how important peer support was for developing a strong team and a new forum for band seven staff across all the theatre departments was being set up during the time of our inspection. Terms of reference were being finalised and meetings were scheduled to commence early 2017.



Innovation, improvement and sustainability

- There was clear indication of improvement since the last CQC inspection in September 2014. During the last inspection there were several breaches in regulation including for discharge planning, medicines management, meeting nutritional needs, privacy and dignity, and sufficient staffing. We found that throughout the service there were improvements in all of these areas. The trust was no longer in breach of the regulations within the surgery service.
- Where any changes to services were made they were always effectively reviewed, assessed and monitored to identify the impact on quality and patient care on an ongoing basis. These were managed within the division. For example, we saw evidence which showed that due to innovation and improvement in thoracic surgery

there were improvements in the patients' length of stay. Another example was within the pain team where the development of a new pathway had improved outcomes for patients suffering with a fractured rib.

- Leaders and staff strove for continuous learning, improvement and innovation. Suggestions to improve the service were actively encouraged and all suggestions were taken seriously. This had resulted in many changes on the wards and in theatres, for example, changes to the organisation of the ward, the introduction of protected nursing meal times, changes to paperwork to improve efficiency. These ideas were encouraged through staff meetings and forums. Staff were encouraged to speak up as they felt no idea was too small or too big and they were always listened to.
- Staff were focused on continually improving the quality of care within the surgical head and neck division and collaborated well with outside organisations and universities to integrate innovation and research within clinical care. This was apparent in cardiac surgery where 90% of patients were given the opportunity to take part in research. The trust worked with The National Institute for Health Research and as a result of grants have two biomedical research units (for cardiovascular disease and nutrition) within the trust, hold programme grants for cardiovascular surgery, eye surgery, and maxillofacial surgery and a plethora of single project grants throughout the division. The trust had been awarded NIHR biomedical research status from April 2017 with the University of Bristol.

Outpatients and diagnostic imaging

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

University Hospitals Bristol NHS Foundation Trust outpatient services are provided on the University Hospitals Main Site at the Bristol Royal Infirmary, Bristol Eye Hospital and University of Bristol School of Oral & Dental Sciences. Outpatient services are split into different service lines relating to specialties.

The trust provides a full range of diagnostic imaging, including general radiography, computed tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine, cardiac imaging, interventional radiology and radiotherapy services at the Bristol Royal Infirmary. Radiography services are also provided at University of Bristol School of Oral & Dental Sciences.

Between July 2015 and June 2016 there were 188,914 patient attendances across the specialties that make up the outpatients department. The specialties where the largest number of patients attended were dermatology, cardiology, physiotherapy and trauma and orthopaedics.

We had previously inspected the outpatients department in November 2014 where the service was found to require improvement in the safe, responsive and well led domains.

We carried out the announced part of the inspection between 22 and 24 November 2016 and an unannounced visit on 1 December 2016.

During our inspection we visited the cardiology, dermatology, trauma and orthopaedics, oncology, gastroenterology, respiratory, endocrinology, dental, ophthalmology, neurology and radiology departments.

We spoke with 60 patients, 12 relatives and 75 members of staff. We observed care and treatment and looked at 11 records of care. We reviewed information relating to performance about the hospital prior to and following our inspection. We also received feedback via comment cards from patients.

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatients and diagnostic imaging service to be good because:

- There was a good incident reporting culture and openness and transparency were encouraged. All staff we spoke with understood and fulfilled their responsibilities to raise concerns. Lessons learnt were shared in both outpatients and diagnostic imaging to make sure action was taken to improve not just the affected service.
- There were clearly defined systems and processes to keep people safe and safeguarded from abuse. All staff we spoke with had a good awareness of safeguarding legislation and what to do if they had any concerns.
- People's care and treatment in both outpatients and diagnostic imaging was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw evidence of audit to ensure that practice was monitored ensuring consistency
- Feedback from patients and relatives had been consistently positive. They praised the way the staff really understood their needs and involved their family in their care. Patients were treated as individuals.
- We found although people were waiting too long for appointments, there were innovative approaches to the appointment booking systems and the management of the capacity and demand of outpatient's and diagnostic imaging clinics. This was under constant review and scrutiny from senior managers.
- In response to the last inspection and feedback from patients, each outpatient department had introduced waiting time boards which displayed the waiting times for each clinic for that day.
- Services were planned and delivered in a way that met the needs of the local population and took into account patient choice.
- There was a clear statement of vision and values, driven by quality and safety. It was translated into a credible strategy for outpatients with defined objectives that were regularly reviewed and relevant.

- Staff and patients were engaged in how care was delivered. Staff felt as if they were active contributors to how the service was developed.

However:

- Some medical records were not being stored securely in outpatient departments.
- There was a backlog of appointments and high levels of referrals meaning people were not able to access the services for assessment, diagnosis or treatment when they needed.
- We found doors to the MRI scanners were unlocked and were accessible to patients in the main waiting area.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:

- There was a good incident reporting culture and openness and transparency were encouraged. All staff we spoke with understood and fulfilled their responsibilities to raise concerns. Lessons learnt were shared in both outpatients and diagnostic imaging to make sure action was taken to improve not just the affected service but also throughout the hospital.
- There were clearly defined systems and processes to keep people safe and safeguarded from abuse. All staff we spoke with had a good awareness of safeguarding legislation and what to do if they had any concerns.
- Staff we spoke with from all levels of the organisation had an understanding of duty of candour, when they would use it and the actions they would take.
- Techniques used ensured cleanliness and infection control measures were in line with National Institute for Health and Care Excellence (NICE) quality standards.
- The environment and equipment kept patients safe.
- Systems for the safe storage and administration of medicines were appropriate and there were audit trails to monitor the use of controlled drugs.
- In both outpatients and diagnostic imaging arrangements for managing medicines and contrast media kept people safe. Contrast and controlled medications were stored in locked cupboards and fridges and fridge temperatures were checked daily to ensure they were in the required range.
- Risks to people who used the service were assessed and their safety was monitored and maintained.

However:

- We found records were not always stored securely. In cardiology and dermatology we found record storage units were not always locked.
- The diagnostic imaging department was spread out over two floors, and had several sub waiting areas which were not always monitored by staff meaning patients were not always observed.

- The imaging service had not ensured non-ionising radiation premises in particular two Magnetic Resonance Imaging (MRI) scanners had arrangements in place to control area and restrict access.
- Mandatory training was below the trust target of 90% completion for medical and dental staff, in particular information governance training which was at 42% and manual handling 64%.
- Diagnostic reference levels, which are used to check the correct amount of radiation is being used to image a particular part of the body were not always calculated and displayed in diagnostic imaging rooms

Incidents

- There was a good incident reporting culture, and openness and transparency were encouraged. Incidents were graded in accordance with the trust risk management policy and risk assessment matrix guide. The guide used the National Patient Safety Agency (NPSA) risk assessment 5 x 5 matrix and was based upon guidance 'A risk matrix for risk managers'. Internal and external reporting requirements were appendices within the trust serious incident policy and policy for the management of incidents. Between September 2015 to August 2016 there were 959 incidents within the outpatient departments, of which two resulted in major harm, 26 moderate harm and 93 minor harm the rest were classified as having negligible or no harm.
- Between April 2016 and October 2016 there were a total of 34 incidents in the diagnostic imaging department, including one incident which was classified as serious. The serious incident was in relation to a missed finding on a scan which had been outsourced to a radiology reporting company. The investigation showed the finding was not related to the reason the patient had the scan, and the scans were double reported, in line with best practice guidelines issued by the Royal College of Radiologists (RCR). Staff understood their responsibilities to report incidents externally. The serious incident relating to a missed diagnosis of a nodule on a CT scan was reported to the Strategic Executive Information System (STEIS).
- A trust policy set out the procedures for reporting, investigating and managing incidents. The policy included incidents relating to patient safety, health and safety, information governance, safeguarding, major outbreaks of communicable diseases, serious IT systems failures, as well as operational and reputational

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incidents. The policy described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process. All staff were responsible for making themselves aware of the contents of the policy and undertaking the parts of the process for which they were involved as and when required. Staff could access the policy via the trust intranet.

- Staff were confident to report incidents using the electronic reporting system and could give examples of when they had used it. All staff we spoke with understood their responsibilities to raise concerns, record safety incidents and near misses and said they felt confident to do so because management listened to them.
- When things went wrong in the outpatients and diagnostic imaging department, investigations were carried out. Most relevant staff and people who used services were involved in the investigations. Staff told us of an incident where an examination had been repeated due to patient movement, but a doctor insisted the radiographer repeat the examination again. An investigation showed not all radiographers were comfortable to challenge senior staff or doctors, so the radiology management team arranged additional training for the radiographer in how to handle similar situations. All staff, including the doctor involved were written to and informed of the outcome of the investigation.
- Lessons were being shared in both outpatients and diagnostic imaging to make sure action was taken to improve not just the affected service but also other services. We saw evidence of feedback and learning from service and trust level being shared at team and staff meetings. Information was also shared in weekly newsletters and during morning safety huddles which took place in individual outpatient departments.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- Staff we spoke with from all levels of the organisation had an understanding of duty of candour, when they

would use it and the actions they would take. They explained there was an open and honest culture with patients even if the incident did not reach the threshold for duty of candour.

- The trust 72 hour report template contained a prompt and section for initial duty of candour. The root cause analysis template contained a section on full duty of candour. These were reviewed by divisional and trust patient safety managers to ensure compliance with quarterly audits for all serious incidents.
- All new staff (excluding doctors), were introduced to the principle of being open and duty of candour during the quality and governance session on induction. A further patient safety session on induction outlined the requirements and expectations for staff when complying with duty of candour. Doctors had a separate induction programme with a patient safety session which contained the same content for duty of candour as for clinical staff. A reminder of duty of candour requirements and areas for improvement from audits were included in three yearly patient safety update sessions for all clinical staff including doctors. Duty of candour was also included as part of the in-house root cause analysis training. There were also resources on the duty of candour intranet pages.

Cleanliness, infection control and hygiene

- High standards of cleanliness were maintained in all areas of the outpatients and diagnostic imaging departments. Areas appeared visibly clean, tidy and clutter and dust free. Equipment was regularly cleaned and staff were aware of this by the use of 'I am clean' stickers and daily cleaning checklists on the doors of clinical rooms. The daily checklists we observed were all completed, dated and signed.
- Disposable curtains were used in all outpatient and diagnostic imaging departments to help prevent the spread of infection. These were dated and changed in line with trust policy.
- In all outpatient and diagnostic imaging areas we saw staff to be observing the bare below the elbow policy. Staff used aprons and gloves correctly to prevent the spread of infections. We saw all staff were washing their hands or using sanitiser gel immediately before and after patient contact which was in line with the National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3). Hand gel facilities were available and clearly signposted in all departments we visited. Staff

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explained how standards of cleanliness and hygiene were maintained. For example, staff could explain the importance of handwashing and limitations associated with using alcohol gel. Hand gel was also available for patients and visitors and these were clearly signposted.

- Cleanliness audits were conducted on a monthly basis to ensure there was continual monitoring of compliance in regards to cleanliness. We saw evidence of these cleaning audits in outpatient and diagnostic imaging departments. Any action was undertaken and reassessed at the next monthly audit.
 - Hand hygiene audits were completed on a monthly basis and we saw records of these. Departments were regularly 100% compliant. We saw these results clearly displayed in the Eye Hospital, oncology, gastroenterology, physiotherapy and dermatology departments however, we did not see them displayed in the cardiology or trauma and orthopaedic department.
 - Reliable systems were in place to prevent and protect people from a healthcare-associated infection. Staff told us patients with suspected or confirmed infections were put at the end of lists to allow cleaning of the rooms and equipment. These systems were regularly monitored and improved when required. For example, the portering system now allowed staff to book patients into timed slots, which staff said had improved the flow and flexibility when trying to arrange imaging lists.
 - Precautions were taken in the diagnostic imaging department when seeing people with suspected communicable diseases, and staff showed us where to find and how to use aprons, gloves and other personal protective equipment.
 - Waiting area furniture was clean and in good condition, able to be wiped clean and fully compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment.
 - Disposable items of equipment were discarded, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full. All bins we saw were stored securely.
- ## Environment and equipment
- The design, maintenance and use of facilities and premises kept people safe within the outpatients departments, but not always in the diagnostic imaging departments.
 - The diagnostic imaging department was spread out over two floors, and had several sub waiting areas which were not always monitored by staff meaning patients were not always observed. However, the department had recently undergone a remodel in some areas such as trauma and orthopaedic x-ray and the main reception area and inpatient recovery areas. In these areas we saw CCTV was used to monitor the waiting areas and patients. In the newly refurbished areas, there was plenty of wipe clean seating and the areas were brightly lit.
 - We saw several large delivery cages containing supplies, bedding and stationary lining the walls of one corridor which patients needed to navigate to gain access to some parts of diagnostic imaging. Staff reported this happened regularly.
 - Equipment in outpatient departments had regular services carried out. All equipment we looked at clearly displayed the date it last underwent a service and date the next service would be required. Within the diagnostic imaging department we saw they had an asset register which monitored the age of equipment as well as service history and helped plan when equipment needed to be replaced. However, two dose metres, which are used to measure radiation doses were waiting servicing to ensure they were accurately measuring doses of radiation.
 - Staff used equipment safely and we saw a detailed competency checklist for each member of staff working in the different radiological areas. Staff told us they updated these every three months and highlighted any examinations or procedures they did not feel confident carrying out.
 - Waiting rooms within the outpatients department were arranged in a way so patients were always visible to reception and nursing staff so patients could be observed and any deteriorating patient detected. We were informed those patient deemed at higher risk of deterioration were sat directly opposite and as close as possible to reception.
 - Waiting rooms within the outpatients departments contained a variety of toys for children as well as televisions and magazines for adults. Coffee and tea machines as well as water coolers were also available for patients.
 - A hoist and trolley were available and maintained for emergency evacuation from the hydrotherapy pool in the physiotherapy department.

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- Consulting rooms contained facilities appropriate to the specialty of the consultant practitioner, for example ophthalmic equipment.
 - We found utility rooms were unlocked. This meant cleaning products were not stored securely and could be accessed by patients, relatives and members of the public. Within the dermatology department we observed a cabinet containing chorine based cleaning products within the unlocked utility room was also unlocked. This was raised with the trust during feedback.
 - Annual business cases were submitted to the trust for refurbishment in most areas. There were plans to revamp the ground floor of the Eye Hospital to provide more consulting rooms which included a temporary move to another area.
 - In the physiotherapy department the hand unit had been refurbished; however, there were still a number of snagging issues to be resolved. There were requests to change the therapy cubicles to treatment rooms and to improve the hydrotherapy waiting facilities. There was an issue with the drains in the changing areas within the physiotherapy department which prevented patients using the facilities. This had been ongoing for some time and had been escalated to the senior management team. There were also problems with the uneven pavement at the entrance to the department and lighting covers at the entrance doors had been removed as they presented a trip hazard.
 - Some clinic rooms were hot and this had been placed on the risk register following staff raising concerns. Business cases had been made for the installation of air conditioning units.
 - Staff told us their offices were small with no windows or air conditioning and could become very overcrowded and uncomfortable.
 - The imaging service carried out prompt and thorough risk assessments for all new or modified uses of radiation. These risk assessments addressed occupational safety as well as consideration of risks to people who use services and the public. New or modified uses of radiation were discussed at the twice yearly radiation protection advisors (RPA) meeting where all risk assessments associated with the change in use were discussed. We saw evidence of RPA audit records where risks and non-compliance were raised and actions plans but in place.
 - The diagnostic imaging department had two MRI scanners which were accessible directly from a corridor which patients could access from the main reception area. Doors from the corridor led directly into the scanners and these were not locked meaning a patient or member of staff could enter and be exposed to the magnetic field.
 - In ultrasound, sonographers reported on their images in the area directly outside the examination rooms, which meant patients had to walk past the reporting stations to get into and out of the examination rooms. Staff told us when they were bringing a patient through the area, they came out of the room first to give the sonographer a chance to close down the report they were working on.
 - The imaging service used diagnostic reference levels (DRLs) as way to check the correct amount of radiation was being used to image a particular part of the body as required under Regulation 4(3) (c) of IR(ME)R 2000 and IM(ME) amendment regulations 2006 and 2011. Some staff were able to locate and explain how they used these as a tool. However, these were not available or displayed in all rooms.
- ## Medicines
- Staff had access to the trust medicines management policy which defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored.
 - We looked at the medicines storage audits, incidents and complaints, storage security, medicines records, and supply and waste-disposal processes. Medicines, including those requiring cool storage, were stored safely and kept within recommended temperature range. During our inspection we found all medicines stored securely, and were only accessible to authorised staff. All cupboards were locked and the stocks well organised.
 - There were reliable systems for storage, recording and the administering of contrast media. Computed tomography (CT) scanners kept contrast containers in warming cabinets which is in line with manufacturers guidance. The department had an electronic automated injection pump, fed by an internal container for the

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contrast. The pump was programmed by staff to administer an amount of contrast over a set period of time. Batch numbers of contrast containers used were recorded on the computer records for each patient.

- The imaging service took account of The Medicines (Administration of Radioactive Substances) Regulations 1978 [MARS]. Each radiologist had in date Administration of Radioactive Substance certificates clearly stating the different licences they held and which radiopharmaceuticals they could administer and for what purpose.

Records

- Patients' individual care records were written and managed in a way that kept people safe. In the outpatients department we looked at 11 sets of paper records. Ten out of the 11 were clearly written and legible. All were accurate, up to date and had any known drug allergies noted.
- Paper records were in use within the outpatients and diagnostic imaging departments with the introduction of a new computer based record system due to be introduced in February 2017.
- Standard Operating Procedures (SOPs) outlined the processes that were followed for the management of health records. Processes for the creation, storage, tracking, access, disclosure and destruction of health records were in line with the requirements of the policy
- The policy applied to all types of health records regardless of the media on which they were held. These included patient health records, X-ray and imaging reports, output and images, photographs, slides, and other images, microform (i.e. microfiche/microfilm), audio and video tapes, cassettes, CD-ROM and DVD, computerised records and scanned records.
- Notes within the outpatients department were not always stored and locked away securely. We found in the cardiology department that record storage bins had been introduced. However, they were not all locked and were not always visible to staff meaning patients and unauthorised staff had access to them. Within the dermatology department records of allergy testing which also contained patients personal information were found in folders stored in unlocked cupboards within an unlocked treatment room. In oncology notes were stored in plastic boxes which were under constant supervision of member of staff. However, confidentiality could not always be assured.

- There were some delays in obtaining patient notes for clinics, particularly for two week wait appointments. These had been raised as incidents on the electronic reporting system and also as a risk on the risk register and were being investigated by the head of clinical preparation. The records prepping team had devised an action plan to look at areas of improvement. Staff had reported that access to records had improved since the last inspection and this was audited at 6 monthly audits. The most recent audit for the outpatients department showed 11,747 out of 11,798 patient case notes were available equating to 99.6% being available.
- We witnessed computers being locked when not in use and these were password protected to prevent unauthorised access to them.

Safeguarding

- There were systems, processes and practices in place to keep both adults and children safe from abuse. Staff had good knowledge of the trust safeguarding policy which was easily accessible on the trust intranet pages. Staff were able to show us the contact information for the safeguarding leads within the trust and local safeguarding services.
- Safeguarding has three levels of training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people. Training records provided by the trust showed as of November 2016 100% of nursing staff had received level two adult safeguarding training against a target of 90% whilst only 88% had completed level two safeguarding children against a target of 90%. This was lower in medical and dental staffing where 76% had completed level two adult safeguarding training whilst only 66% had completed level two safeguarding children training.
- Staff we spoke to were able to demonstrate a good understanding of their responsibilities and the process involved in raising a safeguarding concern. We heard of one example where a safeguarding concern was raised in regards to a patient and their child. The staff worked with both the local safeguarding teams and departments within the hospital to ensure any safeguarding concerns were addressed and the support was given to the patient and child pre- and post-treatment.

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- Staff had attended training regarding female genital mutilation (FGM). This provided instruction for staff on when they were legally required to report any identified or suspected risk from FGM to women and children and how to make these reports.
- Staff were also provided with domestic abuse training to ensure they were able to recognise warning signs in order to safeguard patients. We did not see any information for patients displayed in regards to domestic abuse.
- Information was also contained in the policy on the government's Prevent strategy. Prevent was part of the government's counter-terrorism strategy and aimed to stop people becoming terrorists or supporting terrorism. Prevent focused on all forms of terrorism in a pre-criminal space, and provided support and re-direction to vulnerable individuals at risk of being groomed into terrorist activity before any crimes were committed.
- The trust's safeguarding arrangements were monitored by the trust safeguarding steering group, chaired by the chief nurse and included senior divisional representation. The group reported to the clinical quality group which in turn reported to the quality and outcomes committee and subsequently to the trust board.
- The imaging service ensured the World Health Organisation (WHO) surgical safety checklist was used as a checklist when carrying out non-surgical interventional radiology. An audit carried out in October 2015 showed 34% compliance with all standards measured, which included signing the patient in and out, and dating and signing the checklists. The department had set a target for compliance of 100%, and was planning to re-audit progress in April 2017. During our inspection we observed the WHO surgical safety checklist was carried out for all procedures we observed.
- There were processes in place to ensure the right person received the right radiological scan at the right time. Staff told us they used stop and check procedures as recommended by the Society of Radiographers as well as ID bands.
- staff had received training against a trust target of 90%. This figure was lower for medical and dental staff, in particular information governance where only 42% of medical and dental staff had completed training against the 90% trust target.
- Managers and individuals were informed through an email flagging system of those staff members whose training was due to expire. This email also contained dates of the next available training sessions for these staff to attend. As well as this staff training analysis reports were available to enable attendance to be reviewed, thereby enabling staff and managers to check their compliance with mandatory training. Managers were aware of the current status for staff and details were displayed on white boards in some areas to alert the team.
- The trust provided a programme of mandatory training for staff which included conflict resolution, equality and diversity, fire safety, food safety, harassment and bullying, health and safety, infection prevention and control, information governance, manual handling, safeguarding adults, clinical record keeping and conflict resolution awareness.
- Mandatory training was delivered via classroom based learning and electronic learning. Most staff within the outpatients department reported they were given the time to attend training sessions and it was engaging and responsive to their needs. However, one member of staff told us staffing shortages often meant it was difficult to keep up with mandatory training. One member of staff had stayed on after their shift to complete some on-line training. We were told within the diagnostic imaging department it was becoming harder for staff to be released for face to face training sessions due to the staffing shortages, which staff said had worsened over the last six months.
- A corporate induction and local induction policy created a framework in which all staff, whether temporary or permanent, were effectively introduced to the trust culture, environment and ways of working. New members of permanent or temporary staff attended a corporate induction programme on their first day of employment.

Mandatory training

- Almost all staff received training in the systems and processes which helped keep people safe. Data provided by the trust showed 89% of outpatient nursing

Assessing and responding to patient risk

- Risks to people who used the service were assessed and their safety was monitored and maintained.

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- Staff we spoke with were able to describe the processes involved when managing a deteriorating patient. There were clear pathways and processes for the assessment and management of deteriorating patients within outpatients who were clinically unwell and required hospital admission. In most clinics nurses had acute experience and were able to recognise and manage patients who became unwell and transferred them.
- Due to an increase in the number of unwell patients an emergency blue box had been devised in a number of clinics within the hospital. A413 and A410 and A407 to streamline care. The box contained specific equipment to be able to take blood tests or administer intravenous medication swiftly. This enabled nurses to spend more time with the patient and focus on their treatment and care rather than gathering the equipment. Traditional sphygmomanometers (an instrument for measuring blood pressure) as well as automated observation machines had also been placed in each observation room. This enabled nurses to measure blood pressure readings and pulse rate manually particularly for patients with abnormal blood pressure and to act on the reading as necessary.
- The cardiology department had devised a discrete flagging system for those patients deemed high risk. We observed a high risk patient attend the outpatient department, their attendance was documented in a book and a discrete sign placed on the patients notes. Staff involved in the patient's care were then informed. These patients were also directed to sit directly in front of the reception desk so they could be monitored.
- Risk assessments were carried out in line with national guidance. We were informed in dermatology they had adapted the World Health Organisation (WHO) safer surgery checklist to ensure the minor procedures they undertook were done so in a safe way. The radiology department required women to sign to confirm they were not pregnant prior to undergoing any radiation exposure.
- The radiation protection advisor was easily accessible for providing radiation advice. There was a dedicated team of physics experts based at the hospital who were available for advice and support and carried out regular checks and audits of equipment to ensure it was safe to use.
- The imaging services had appointed radiation protection supervisors (RPS) in each clinical area, and they attended the twice yearly radiation protection advisor meetings at least once a year. The radiation protection supervisors were responsible for feeding risk assessments for new or modified uses of radiation into the agendas for the meeting, and were subsequently involved in discussions around them.
- The diagnostic imaging service ensured the 'requesting' of an X-ray, MRI, nuclear medicine or other radiation diagnostic test, was only made by staff or approved persons in accordance with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Staff told us they regularly contacted GP surgeries to update the list of doctors approved to request diagnostic imaging. Staff also told us they kept an up to date list of non-medical requesters (such as nurses). The department had been involved in a project with two other large acute NHS trusts nearby, to standardise the protocol for non-medical requestors, which clearly set out what they could and could not ask for. The policy also covered IR(ME)R training which all non-medical requestors had to undertake before they were signed off. The radiation protection advisor team based at the trust were supplying all training to non-medical requestors in the geographical areas of the three trusts.
- There were signs and information displayed in the radiation department waiting area informing people about areas and rooms where radiation exposure took place, however we saw a corridor leading off the waiting area to an X-ray room where the access door was propped open.
- There were local policies for the risk assessment and prevention of contrast induced nephropathy, and staff were aware of these policies which were in keeping with the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Radiologists standards for the administration of intravascular contrast agent administration. Staff told us estimated glomerular filtration rates (eGFR) were always checked for patients receiving iodinated contrast agents. Staff said this was not always done when requests were vetted, but was always done and documented on the radiology computer system before any intravenous contrast was given to a patient.

Nursing and allied health professional staffing

- Staffing levels within the outpatients department compared well to the planned level and thus kept

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patients safe at all times. The outpatients department reported in July 2016 they had an over establishment resulting in a vacancy rate of minus 0.6% for nursing staff.

- Staff reported they tried not to use bank and agency staff and where possible when sickness or leave occurred these shifts would be covered by staff within the department. Between September 2015 and August 2016 the outpatients department reported a bank and agency usage rate of 0.9%.
- Staff within the diagnostic imaging department did not feel levels were sufficient to meet the needs of the service. At the time of our inspection there was one vacancy within the diagnostic imaging department. Senior members of staff felt current staffing levels meant the computed tomography (CT) scanners could not always be run as efficiently as possible and staff were often working alone.

Medical staffing

- Staffing levels and skill mix were planned and reviewed so people received safe care and treatment at all times. The diagnostic imaging department had constructed and adapted a staffing model. The model had shown the department needed 10 more radiologist posts to meet all targets, and the department had been increasing the number of radiologist post by two per year for the two years prior to our inspection, alongside training radiographers to report some examinations to help meet internal and external targets for waiting times and report turnaround times.
- Within the outpatients department, consultants held regular clinics and were responsible for the care of their patients. In July 2016 a vacancy rate of 3.4% was reported for medical staff with a turnover rate of 10.4%.
- Sickness rates were reported as 0.4% in July 2016 with a bank and locum usage rate of 0.3%
- All doctors who were employed at the trust in January 2013, who continued to practice had undergone revalidation of their licence.

Major incident awareness and training

- There was a trust business continuity plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences

caused by a significant disruptive event ranging from a technology failure to an influenza pandemic. The staff we spoke to were aware of the plan and how to access this on the trust intranet system.

- Systems were in place to manage computer system failure. The diagnostic imaging department had a continuity plan to manage a loss of their RIS and PACS computer system and ensure patient safety.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Although we inspected the effective domain in outpatient and diagnostic imaging services we did not rate them due to the lack of national data available to the CQC. We found that:

- Patients' care and treatment in both outpatients and diagnostic imaging was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- Both the diagnostic imaging service and outpatient services benchmarked against each other and actions were put in place to improve outcomes.
- Staff had the right qualifications, skills, knowledge and experience to do their jobs when they started their employment, when they took on new responsibilities.
- All necessary staff, teams and services were involved in assessing, planning and delivering patients care and treatment.
- The systems that managed information about patients supported staff to deliver effective care and treatment.
- Staff we spoke with understood the relevant consent and decision making requirements of legislation and guidance including that of the Mental Capacity Act 2005.

However:

- The diagnostic imaging service did not always ensure it met best practice clinical guidance for report turnaround time for medical staff requesting diagnostic imaging to be carried out.

Evidence-based care and treatment

- Relevant and current evidence based guidance; standards, best practice and legislation were identified

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and used to develop services in outpatients and diagnostic imaging. Any alerts or information were shared at either safety briefings or staff meetings. For example, in dermatology they had introduced a minimal erythmic device which is a device to indicate the strength of light that can be administered to patients, this was in line with the British Association of Dermatologists guidelines and helped reduce the number of appointments patients needed to receive and reduce the level of UV exposure. The dermatology department were also due to start photodynamic therapy for superficial treatment of basal cell carcinomas, this would reduce the number of patients having to undergo surgery and thus also reduce surgery wait times.

- Compliance with current evidence based guidelines was monitored. Within the dermatology department an audit had been undertaken to assess whether clinicians were following 2012 clinical guidelines surrounding the assessment of patients. It was determined some areas of assessment were not always being completed, learning and training from this audit was shared with staff to assure full completion of assessments.
- National Institute for Health and Care Excellence (NICE) guidance were followed in both the outpatients and diagnostic imaging departments. The rheumatology department followed NICE guidelines for the care pathway for patients with rheumatoid arthritis. The diagnostic imaging department ensured it followed NICE guidelines for acting on radiologist reports, such as NICE quality standard 17 for suspected lung cancer. Staff described how they flagged urgent reports to GPs, and followed this up to ensure the report and its recommendations had been followed up on. We saw the department had a standard operating procedure (SOP) in place to deal with unexpected findings of which staff were aware.
- The Commissioning for Quality and Innovation (CQUIN) payment framework enabled commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. A CQUIN was in place for the development of a resource to illustrate the '3 Questions' that patients should be asking with reference to their treatment options. This resource was used at the haematology and oncology centre and the heart

institute for cardiology and oncology. As part of this CQUIN, 8000 A5 postcards and 10 A3 posters were designed and produced to educate patients about the '3 questions they should ask.'

- Patients were encouraged and supported to make informed decisions about their treatment and healthcare and were provided with information that assisted them in asking questions about their treatment they might otherwise find challenging. The objective was to roll out a resource for patients in 2015/2016 that would explain the '3 Questions' to ask to support them when making treatment decisions. The resource was included in the patient information pack that was sent out to all new patients with the appointment letter for their first outpatient appointment.
- Clinical teams were supported to engage with patients and their carers and families to learn about what was important to them, through structured conversations about treatment decisions. This is also included the use of 'This is me' documents which contained information about patients history, likes and dislikes.
- Physiotherapists participated in national benchmarking and interest groups and network sharing with other hospitals.
- The Society and College of Radiographers produced 'Pause and Check' resources to reduce the number of radiation incidents through misidentification occurring within radiology departments. For all examinations we observed, staff using the pause and check method and 'pause and check' posters were displayed in every room.
- The diagnostic imaging service incorporated relevant and current evidence-based best practice guidance and standards, to develop how services, care and treatment were delivered. For example, the National Institute for Clinical Excellence (NICE) recommends computerised tomography of the chest and abdomen in patients who suffer an unprovoked deep vein thrombosis (blood clot), which the department had integrated into its CT protocols.

Pain relief, nutrition and hydration

- In each outpatient department there were tea, coffee and water facilities available for patients. Snack boxes were stored for those patients who required them as well as vending machines and cafes throughout the hospital with clear signposting to these displayed in departments.

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- Staff said it was unusual to have to ask patients in outpatient clinics to rate their pain although all staff demonstrated a good understanding of simple comfort scale methods available to them for the management of patient's pain.

Patient outcomes

- A governance framework was in place to ensure a range of outcomes were reviewed and discussed.
- Patient outcomes such as “did not attend” and cancellation rates were monitored in each outpatients department as well as centrally by the appointment booking centre. Clinics were then benchmarked against each other and actions put in place to improve outcomes. We were informed that the appointment centre had conducted a short survey regarding the effectiveness of text reminders by making changes to the language used. In a separate work stream the trust were introducing the option for patients to have their appointment letters sent by email, in order to reduce the number of patients that did not attend clinics. They were also in the process of introducing email reminders.
- Patient outcomes were also assessed through audit and annual review. Within the dermatology department outcome data for each case of skin cancer excision was collected and then benchmarked. The Trust informed us the most recent data showed reduced re-operation rates.
- The diagnostic imaging department was preparing to submit documentation in preparation for an inspection by the Imaging Services Accreditation Scheme (ISAS). Previously the diagnostic Imaging service used ISO9001 as their set of quality standards for the diagnostic imaging department. Staff preparing the documentation for the inspection told us they had found the process very useful as it had made them look at and improve their internal processes and procedures. The department had set a target to achieve accreditation by September 2017. The Imaging Services Accreditation Scheme is an assessment and accreditation programme which covers a list of quality standards covering quality, delivery, safety and patient experience.
- In addition to the work surrounding ISAS accreditation, the imaging department also participated in South West

benchmarking. Managers attended the South West regional radiology managers group where benchmarking in regards to agency costs, staffing levels, vacancies and scanner utilisation was looked at.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their jobs when they started their employment, or when they took on new responsibilities. For example, a number of band 5 radiographers had been allowed to undertake a formal qualification in CT as part of their training, and the department had seven reporting radiographers who had also undertaken formal training in order to issue reports on certain types of plain film X-rays. However, some staff were concerned junior staff were being left alone in CT before they were confident to run the scanner unassisted.
- Staff had their learning needs identified through an appraisal. However, during the financial year 2015 to 2016 only 79% of staff within the outpatients department had received an appraisal against a trust target of 85%. The appraisal rate for medical and dental staff was a lot lower with only 35% of staff receiving an appraisal. Staff who had received an appraisal informed us they felt they were a worthwhile process where their developmental needs were addressed and acted on.
- Staff were supported in the revalidation process. Staff we spoke to reported they were given the time to attend continuing professional development training and time was also given for them to complete the revalidation process. There was a commitment to training and education within outpatients. Staff felt well supported to maintain and further develop their professional skills and experience. They were encouraged to develop their knowledge and skills and were supported in their continuous professional development. There were opportunities to attend external training and staff were able to apply for full or partial funding depending on the appropriateness for their job role.
- Most staff we spoke with were positive about the quality and the frequency of clinical supervision they received.
- Attendance was monitored by managers with follow up for non-attendance ensuring staff received training and regular updates for maintaining a level of competence appropriate to each individual's employed role.
- All staff administering radiation were trained to do so. Those staff who were not formally trained in radiation

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administration, were always adequately supervised in accordance with legislation set out under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), and we saw students working alongside qualified radiographers, who provided supervision and guidance for the students.

- An inability to recruit to some specialist roles had meant the diagnostic imaging department had developed an internal career pathway for some of the radiology assistants to follow. For example, one member of clerical staff had re-trained to provide Dual-energy X-ray absorptiometry (DEXA) imaging.
- There were clear records showing which radiologists were entitled to administer radioactive medicinal products and we saw records detailing which staff had the necessary certificate from 'The Administration of Radioactive Substances Advisory Committee' (ARSAC).

Multidisciplinary working

- All necessary staff, teams and services were involved in assessing, planning and delivering patients care and treatment. We were told relationships between the outpatient departments were good and learning was shared. For example, the use of discrete labelling of patient notes to highlight to staff patients who were medically compromised or may require additional help for example patients with pacemakers, at risk of falling or visually impaired, was in use in both the cardiology and gastroenterology departments.
- The outpatient departments worked well with the local GPs in the area to help plan and deliver care. We were informed due to the high level of patients not attending appointments (DNAs) in the chest pain clinic, the cardiology department had worked with local GPs and determined a daily drop in chest pain clinic would be more effective. This had improved DNA rates and enabled GPs to give patients more options and flexibility to attend appointments.
- Staff were aware of the need to work well with social care services in the area. We were informed of incidences where social care members of staff attended multidisciplinary meetings to ensure patients received a more comprehensive package of care.
- As part of the justification process to carry out exposure to radiation, the imaging service always attempted to make use of previous images of the same person requiring the test, even if these have been taken

elsewhere. The trust had an image exchange portal (IEP), which meant images could be transferred between hospitals at any time of day or night. Senior managers told us the system could be difficult to use for clinicians who were not familiar with it, and some problems had arisen when staff tried to search for patient images with the trust's unique reference number, rather than the patient name or NHS number. Staff told us, radiographers were often able to help with simple queries, but for more complex questions, there was a member of the picture archiving communications (PACS) team on-call.

- The diagnostic imaging department had a number of images which it had been agreed, did not need a formal report. There was a policy outlining how these images were selected, and covered follow up X-rays for inpatients and any subsequent X-rays in the same patient episode, unless the referring doctor asked for a report.
- Managers told us it was the responsibility of the referring doctor to record any findings from imaging in the patients records. However when this had been audited, the results showed this had not been happening in all cases. Following a period of retraining, the diagnostic imaging department re-audited a sample of notes in August 2015 to see if this had improved. The results showed this had improved and 80% of the records looked at, image findings were being recorded. The radiology team was engaging with different teams to improve this result further.

Seven-day services

- Most outpatient services ran a traditional five day service. However, if demand was particularly high then some services had arranged weekend or out of clinics on an ad hoc basis. When clinics were closed and patients required advice or help they were directed to their GP, 111 services or the accident and emergency department. We were informed in the trauma and orthopaedic department that patients could leave messages if the clinic was not open; these messages were then flagged to the department during their opening times.
- Some diagnostic imaging services were available seven days apart from interventional radiology (IR) and nuclear medicine. Full access to CT, MRI and ultrasound (including formal radiological reporting) had weekend availability limited to emergencies only. However, the

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performance of non-emergency CT and MRI scanning (with radiological report pending) was also undertaken at weekends. There was no vascular service and consequently an interventional radiology capability was limited to normal hours, with an informal arrangement with another NHS organisation for emergency provision. Plans were proposed including formalisation of interventional radiology arrangements with the other NHS organisation and development of an in-house non-vascular interventional radiology service and formal dialogue was underway to progress this.

- Physiotherapy appointments were available on some Saturdays to help with patient flow.

Access to information

- Most of the information required to deliver effective care and treatment was found in patient case notes. The availability of these is a requirement of NICE quality statement 15 (statement 12) which states patients should experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. An audit into the availability of these notes was carried out on a six monthly basis with the last audit carried out in April 2016 showing 11,747 out of 11,798 patient case notes which equated to 99.57% being available and 0.43% unavailable.
- At the time of our inspection the outpatient departments we visited were using paper records. We were informed the introduction of a computer based record system was due to go live in February 2017. It was felt this would improve access to patient records and the sharing of information between departments.
- The systems that managed information about patients supported staff to deliver effective care and treatment. For example, senior managers showed us they had integrated the referrer programme into their electronic requesting system, so guidance on which test to request was always and immediately available to referrers not just in the hospital, but in the GP surgeries and other locations in the community. Ireferrer is an information database created and maintained by the Royal College of Radiologists which provides up to date best practice guidance on requesting diagnostic imaging.
- The diagnostic imaging service provided electronic access to diagnostic results for all referring staff in the

hospital via its requesting system and also for all clinical staff via its PACs system. The same electronic referring system also allowed GPs and other community referrers to access results electronically.

- When patients moved between teams and services or hospitals the information needed for their ongoing care was shared appropriately and in a timely way. Staff were able to clearly tell us the different ways images were shared securely depending on the receiving organisations computer system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff were aware of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act and deprivation of liberty training was fully incorporated into safeguarding training. Staff had attended mandatory training and knew what their responsibilities were and how to apply them within everyday practice. In both the outpatient department and diagnostic imaging extra time would be allowed for an appointment if staff were made aware a patient had learning difficulties and may require extra time.
- Staff had a good knowledge and understanding of the processes involved in determining whether a patient had capacity, how to gain adequate consent and their responsibilities surrounding this. We heard of an example where a nurse challenged a doctor's decision surrounding a patient's capacity. It was deemed the patient lacked capacity consent so an Independent Mental Capacity Advocate was contacted to attend and help ensure decisions were made in the patients best interest.
- Staff said they obtained consent from patients prior to commencing care or treatment. They said patients were given choices when they accessed their service.
- Throughout the inspection we saw staff explaining the assessment and consent process to patients and any need to share information with other professionals such as GPs, before obtaining written consent. We saw consent forms were signed by patients.
- We heard staff discussing the treatment and care options available to patients.
- Radiographers who were delivering radiotherapy treatment or undertaking a clinical imaging examination had a duty of care to ensure that patients were fully

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aware of the procedure and had consented. The radiotherapy department had a consent procedure which was part of its Quality Management System. An audit had been conducted where documentation was analysed for 50 eligible patients. Results showed 100% of consent forms were present at the time of the audit and had been signed by the clinician; 98% of patients had signed their consent form before treatment commenced and 87% had confirmation completed before treatment commenced.

- Where it was deemed patients had capacity, staff still recognised the need for relative's involvement in supporting patients to make a decision. We observed carers and relatives being encouraged to attend clinic appointments.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- Feedback from patients and relatives had been consistently positive.
- Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe.
- Staff were skilled to be able to communicate well with patients to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Relatives were encouraged to be involved in care as much as they wanted to be, while patients were encouraged to be as independent as possible.
- We observed staff treating patients with kindness and warmth.
- Staff talked about patients compassionately with knowledge of their circumstances and those of their families.

Compassionate care

- We spoke with 60 patients and 12 relatives in the outpatient departments and all were overwhelmingly

positive about the care and treatment they had received. Patients told us they had received compassionate and sensitive treatment and care by staff.

- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. We saw all staff going the extra mile to support patients' personal and cultural needs. For example, staff made great efforts to pass on specific needs about a patient to the surgical team to ensure a smooth transition.
- During our inspection we observed excellent interactions between staff, patients and their relatives. We saw these interactions were very caring, respectful and compassionate. For example, when a patient became concerned about the length of time their relative had been waiting for them a member of staff went to find the relative to let them know how much longer they would be waiting. The member of staff returned to reassure the patient.
- Staff were skilled in talking to and caring for patients. Patients were encouraged to be as independent as possible and relatives were encouraged to provide as much care as they felt able to. We observed all staff taking time to talk to patients. They involved and encouraged both patients and their relatives as partners in their own care. We observed staff asking relatives, with the patients consent, if they would like to attend consultations
- There were positive results from patient satisfaction surveys with data from the diagnostic imaging department showing between 95 and 100% of patients would be either likely or extremely likely to recommend the service to friends and family if they needed similar treatment or care.
- Patients we met spoke highly of the service they received. All the feedback we received from the patients was very positive about the care they received. The comments we received during our discussions with patients included, "the staff have been fantastic", "I'm very happy with the care I've had ... I can't fault it." Patients in the diagnostic imaging department were also unanimous in their praise and comments included, "the staff are amazing, kind and lovely", "I was really scared about the scan but the staff explained everything and helped me to stay calm", "They really know their stuff."
- A chaperone policy set out the policy and standard operating procedures for promoting the privacy and

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dignity of patients. We observed good attention from all staff to patient's privacy and dignity. We observed voices being lowered to avoid confidential or private information being overheard on arrival at reception areas. All patients said their privacy and dignity was maintained. However, we saw in the main waiting area of radiology, there were double doors which led into a patient recovery area. The central panels in the doors were glass, which meant people in the main waiting area could see clearly into the recovery area. Also within the outpatient department we observed a door left open and the conversation with the patient and their relative could be overheard and did not guarantee privacy and confidentiality.

- Care from the nursing, medical staff and support staff was delivered with kindness and patience. We observed staff giving patients the time to respond. The atmosphere was calm and professional without losing warmth and reassurance.
- In the main X-ray waiting area, patients were not always able to speak to the receptionist without being overheard, this could include confidential information.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. We observed staff explaining things to patients in a way they could understand. For example, during a complex explanation, time was allowed for the patient or their relative to ask whatever questions they wanted to.
- Patients and relatives were encouraged to be involved in their care as much as they felt able to. Patients we spoke with all confirmed this was the case. One patient said "I've felt very much included in the planning of my treatment and I'm very happy with everything."
- All healthcare professionals involved with the patient's care introduced themselves and explained their roles and responsibilities.
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. They were knowledgeable, compassionate and patient when dealing with communication with families who were non-English speakers, or for whom English was a second language as well as patients with hearing or visual impairment, or who had learning disabilities.

Emotional support

- We observed staff providing emotional support to patients and relatives during their visit to the department. Patient's individual concerns were promptly identified and responded to in a positive and reassuring way. One patient who regularly attended the department said "nothing was too much trouble for the staff ... from the doctors and nurses to the administration team."
- Patients and their relatives were spoken with in an unhurried manner and staff checked if information was understood. We overheard staff encouraging them to call back at any time if they continued to have concerns; however, minor they perceived them to be.
- Opportunities for patients to ask questions or raise any concerns was also observed during consultations. Staff responded in a reassuring and knowledgeable manner and a patient told us they felt "so much more relaxed about the whole thing ... and I know can phone if I need to go over what to do again."
- Staff understood the impact the care, treatment or condition might have on the patient's wellbeing and on those close to them both emotionally and socially. Staff told us they felt they not only had a duty of care to the patients but also to their families.

Are outpatient and diagnostic imaging services responsive?

Good



We rated responsive as requires good because:

- In response to the last inspection and feedback from patients, each outpatient department had introduced waiting time boards which displayed the waiting times for each clinic for that day.
- Services were planned and delivered in a way that met the needs of the local population and took into account patient choice.
- Lessons were learnt from complaints and were disseminated well to different teams with people informed of the outcomes.
- The trust was performing better than the national standard of 93% by seeing 94% of patients within two

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weeks for urgent GP cancer referrals. It was also achieving above the national operational standard, 96%, for people waiting less than 31 days from diagnosis to first definitive treatment.

- The trust's diagnostic and imaging departments were achieving a trust total of 98.9% of the percentage of patients seen within six weeks. This was above the national average of 98%.
- A central appointment booking system had been introduced to improve responsiveness to referrals and members of the public.
- Tea and food was actively provided for all patients who required transport or had a medical condition where blood sugar levels had to be maintained.

However:

- In the outpatients departments the overall referral to treatment standard on average was slightly worse than the national average between September 2015 and August 2016. In particular within the gastroenterology 48.6% and oral surgery department 64.3% of patients were seen with 18 weeks.
- Of the patients classified as urgent 18% were not seen within the two week target.
- Patients were not always able to locate the outpatients and diagnostic imaging departments because they were not clearly signposted.
- The parking facilities did not always meet the demand leaving patients unable to find a space in a timely manner.
- Each outpatient department had a wide selection of information leaflets available to patients; however, they were not available in other languages.

Service planning and delivery to meet the needs of local people

- Appointments were arranged where possible around the needs and requirements of the patient. The diagnostics and therapies division had introduced a patient survey with the most recent data showing 87% of people were given a choice of appointment time if they wanted one. Patients informed us staff where flexible and listened to their needs.
- A central appointment booking system had been introduced to increase response times to patient phone calls and ensure all available clinic space was utilised. An audit of the number of patient phone calls answered within 60 seconds showed prior to the appointment

booking system 40% of calls for the dental department were being answered within the targeted time, this had improved to 64% following the dental department moving to the central appointment booking system. At the time of the inspection not all outpatient departments were using the central booking system; however, there was a plan in place for this to occur in the future.

- In response to the last inspection (in September 2014) and feedback from patients, each outpatient department had introduced waiting time boards which displayed the waiting times for each clinic for that day. We found generally clinics ran on time and an audit of waiting times showed 91% of patients were seen within 15 minutes. However, an audit of the waiting times in the diagnostic imaging and the therapies department showed that only 58% of patients were informed how long a delay there would be (if over 15 minutes) and only 53% informed as to the reason for the delay. At the time of our inspection there was a system being developed so reception staff could inform patients of a more accurate waiting time when they checked in for their appointment.
- Changes had been made to the delivery of some services in response to the needs of the patient. The chest pain clinic within the cardiology department had been experiencing a high level of patients who "did not attend". In response to this the service had decided to run open chest pain clinics on a daily basis, giving patients greater flexibility and access to the service.
- Patients were not always able to locate the outpatients and diagnostic imaging departments because it was not clearly signposted. Staff told us the trust had recently changed the system of signage to a combination of letter and numbers (for example A217). Some patients had mentioned it was difficult to identify which number should correspond with the department they were looking for.
- Information was provided to patients in accessible formats before diagnostic imaging appointments, which included information about contact details, a hospital map and directions, the consultant's name and information about the examination the patient was coming for.
- Patients raised concerns around travelling to and from the hospital especially the difficulties in parking once

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arriving at the trust. This was particularly difficult when accessing the cardiology department where patients with cardiac problems would often have to walk up a steep hill.

- Whilst the vast majority of paediatric examinations took place at a nearby specialist hospital, some children still did need attend the department for specialist tests. The facilities for children in waiting rooms were not always adequate, and the small area designated for children was dark and was not easily seen by staff.
- There were a number of satellite serves available at a number of locations across the area. Oncology outpatient clinics were held at a GP practice and a community hospital and eye clinics were held at a GP practice and a mobile ophthalmic clinic at a shopping centre.

Access and flow

- Referral to Treatment (RTT) timeliness was monitored on a weekly basis in the Surgical, Head & Neck division which was reported to the trust board on a monthly basis. Each sub-specialty within the directorate reported to a RTT lead who held them to account for actions against an action plan and discussed individual patients who were waiting longer than 18 weeks with consultants to ensure the patients at highest risk were seen first. In outpatients referral to treatment standards (within 18 weeks) on average were worse than the national average between November 2015 and October 2016. In particular, gastroenterology which was only achieving 48.6% against a national average of 85.5%. Other areas that were significantly below the England average for referral to treatment times were, oral surgery, neurology, cardiology and trauma and orthopaedics. Some departments were above the national average for referral to treatment times, this included rheumatology, ophthalmology and ear nose and throat. Overall from September 2015 to October 2016 the trust was achieving 90% of patients being seen within 18 weeks against an operational standard of 92%. Where there had been a slip in performance there were clear actions to address these which had been proven to be effective. This was recognised by the trust and, for example, in cardiology, weekend clinics were provided and consultants were held to account if the number of patients there were seeing was below average.
- There was a high demand for therapy outpatient appointments and the team had concerns about the

backlog of appointments. A telephone triage system in physiotherapy was in operation every day. Physio Direct enabled patients to talk to a qualified physiotherapist about their problem following an initial referral from their GP or consultant. An exercise plan or an appointment to attend a clinic assessment was arranged if required. There were plans to extend the service to include patients from more GP practices.

- Urgent GP cancer referrals need to be seen within two weeks to ensure timely diagnosis and treatment. The trust was performing better than the national standard of 93% by seeing 94% of patients within two weeks. It was also achieving above the national operational standard, 96%, for people waiting less than 31 days from diagnosis to first definitive treatment.
- The most recent 'Do Not Attend' (DNA) data provided by the trust showed between April 2015 and March 2016 rates were better than the England average of 6%. Reasons were monitored to look for themes and actions taken to address any problems. The appointment booking team had looked at whether the way in which patients were reminded of appointments, by phone or text, helped improve DNA rates.
- The diagnostic and imaging department was achieving a trust total of 98.9% of the percentage of patients seen within six weeks. This was above the national average of 98%.
- The diagnostic and imaging department managers met monthly to go through the current reporting backlog and prioritise those deemed to be high risk. However, at the time of our inspection there were 187 patients who had been categorised as urgent and needing to be seen within 2 weeks. Of the 187 patients 34 had been waiting over 2 weeks which equates to 18%. This meant patients could be deteriorating and their condition worsening whilst they were awaiting imaging. Risk assessments were carried out for each of these patients during weekly divisional level where action plans were put in place and patients who required more urgent imaging would be allocated an inpatient slot if necessary. A patient tracking list was also used at departmental level which looked at utilising any cancelled slots
- Care and treatment was only cancelled or delayed when absolutely necessary. Patients told us cancellations were always explained to them, and they were supported to access care and treatment again as soon as possible. Investigations into the reason for an 11.8%

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hospital cancellation rate within the outpatients and diagnostic imaging department had been undertaken by the outpatient steering group and work streams were in place to try and address the causes.

- Patients were advised chaperones were available to support them at any time during their appointment and advised to ask a member of the nursing team. Posters informing patients of this were displayed in each department.

Meeting people's individual needs

- Services were planned to meet the needs of individuals. The cardiology and gastroenterology department had devised a discrete flagging system to highlight patient's individual needs. This included patients that were living with dementia, were visually impaired or diabetic. This information was then shared with staff so support could be given. Patients who were flagged as being diabetic would then be offered a snack box containing food to ensure they maintained a safe blood sugar level. Each outpatient department had a dementia lead and staff received training in dementia and learning disability awareness as part of their training.
- Transport services were available for patients with mobility problems. Staff reported sometimes patients were dropped off early or had to wait to be picked up. Staff ensured that if a patient arrived early they would try and arrange to see the patient as soon as possible and any patient waiting for transport was offered a drink and a snack box.
- There was disabled access to all the outpatient and diagnostic imaging departments, and the reception desk had a lowered section for wheelchair users in most clinics. The dental hospital had recently obtained a bariatric chair as well as replacing the existing dental chairs to ones that had a greater weight limit. However, some departments were more difficult to access than others. The dermatology department was situated in a position which required patients to navigate numerous corridors and areas outside which may prove difficult for patients with mobility issues.
- The trust had a number of translation and interpreting services which were accessible for patients. Face-to-face, telephone and written interpreting provided access to 35 different languages. All interpreting services were available 24 hours a day, 365 days a year. The service was used for translating documents such as internally produced patient information leaflets, patient letters and notes. For patients with visual impairments, the trust used a local company to provide translation of documents into alternative formats including Braille. Interpreting services for the deaf were available and included British Sign Language. Staff could tell us how they would access the services.
- Religious needs of patients were also met and respected. The department of spiritual and pastoral care (chaplaincy) provided spiritual, religious and pastoral care to patients, relatives and carers: people of all faiths and those of none. The chaplaincy also provided a confidential listening ear for staff and could help with ethical questions, and de-briefing after difficult and traumatic incidents. The cardiology department had clear protocols and guidelines regarding blood transfusions and the treatment of patients who did not want to receive them. Staff informed us the views of the patient were always respected and they were involved in any decision made.
- Support was sometimes available for bariatric patients. For example new CT equipment commissioned by the diagnostic imaging service had an increased table weight limit and a larger area for patient to pass through the scanner.
- The diagnostic imaging service arranged appointments so that new patients were allowed time to ask questions and have follow-up tests at their first appointment. The outpatient services arranged appointments so that new patients were allowed time to ask questions.
- Patients were telephoned a few days prior to their appointments in thoracic and respiratory clinics to inform them of their X-ray or CT scan appointments. This enabled doctors to review patients' results and to make timely decisions for patients and make plans of care and treatment.
- For patients attending their first oncology outpatient appointment a talk was available three times a week outlining what to expect during treatment, the local support services available and details about financial assistance. One patient said this had been "extremely helpful and reassuring for me and my family,"
- The dermatology department was involved in a tele-dermatology service encompassing Bristol and North Somerset Clinical Commissioning Groups. This enables GPs to gain secondary review with immediate feedback meaning patients were not always required to attend the hospital.

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- The rheumatology department had established a direct access system for people with rheumatoid arthritis. This involved a 24 hour helpline and short notice clinics. This had resulted in a 30% saving in appointments and had been recognised with a Guardian Public Access Award with the system being adopted by departments nationally and internationally.
- Each outpatient department had a wide selection of information leaflets available to patients. These leaflets contained advice and guidance regarding medical conditions, hospital procedures and how to make a complaint, however, they were not available in other languages.
- Where lessons had been learnt from concerns and complaints this was shared with the complainant. Radiation incidents were discussed at radiology clinical governance meetings. Learning from complaints was shared at governance and team meetings as well as during morning safety huddles within the outpatient departments. We saw evidence of this in safety huddle meeting minutes. This ensured information was shared throughout the Trust. We heard an example of how a complaint had been dealt with in line with these procedures.

Learning from complaints and concerns

- Between February 2016 and August 2016 there were 22 complaints about outpatient services. The themes included attitude and communication, appointments, clinical care, information and support. The trust took an average of 21 days to investigate and close these complaints.
- Patients and visitors we spoke with did not all know how to make a complaint or raise a concern. However, they all reported they would feel confident in not only enquiring how to do this but also in raising the complaint. Information regarding how to make a complaint was found on the trust's web site, a patient information leaflet, 'Tell us about your care' posters and the patient support and complaints service and the 'LIAISE' service (the PALS service in the Children's Hospital). These were available in easy-read format and had been translated into non-English languages.
- All new staff were provided with information during corporate induction about how to deal with a complaint informally if approached directly in their place of work. Training was also provided by the patient support and complaints team to give frontline staff the confidence to deal with complaints informally and "on the spot".
- Concerns were encouraged through feedback forms and friends and family questionnaires. Each outpatients department displayed a 'you said we did' board. This contained patients concerns and the actions taken. We were informed by a patient that they had raised a concern with one of the outpatient departments, they reported the department contacted them to discuss their concern and action and change had occurred to address it.

Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

- There was a clear statement of vision and values, driven by quality and safety.
- Staff and patients were engaged in how care was delivered and staff felt as if they were active contributors to how the service was developed.
- There was a clear governance framework that ensured people's responsibilities were clear and quality, performance and risks were understood and managed.
- The culture centred on the needs and experiences of people who used the services.
- Frontline staff and managers were passionate about providing a high quality service for patients.
- There was a high level of staff satisfaction with staff saying they were proud of the departments as a place to work.

However:

- Staff expressed concerns at some leader's inconsistent approach to staff personal or sensitive issues.

Vision and strategy for this service

- There was a clear vision and values for the service which put patient care and quality of care at the forefront of the service. Staff had a good understanding of the core trust values of: respecting everyone, embracing change,

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recognising success and working together; and were committed to providing patient-centred care. The values of the organisation were displayed on the walls of the outpatient departments.

- We saw a detailed strategy to achieve the vision for the outpatient department where services worked together to improve whilst maintaining effective working relationships within their divisions. This strategy was aligned with the trust strategy.
- Outpatient managers informed us the progression of the outpatients' strategy was reviewed at an outpatients steering group. We saw evidence of this in the meeting minutes for this group where issues such as waiting times, the appointment booking system were discussed. The outcome of these meetings were shared with the department managers with information being further disseminated in team meetings.
- The trust had a vision for the diagnostics service, which included a programme of financial bids for equipment and staff for the coming financial year, based on urgency and need, and also a longer term operating plan, which took the service forward into 2018/19. Staff were aware of these bids and plans through a series of manager engagement initiatives to include staff in the planning of the future of their services.
- There was a realistic strategy for achieving the priorities set for the diagnostic imaging service. The senior management were realistic in their request for staffing and equipment, and backed their bids up with operational evidence, such as using the reporting backlog to justify training reporting radiographers in chest and abdomen reporting.

Governance, risk management and quality measurement

- There was a clear governance framework that ensured staff responsibilities were clear and that quality, performance and risks were understood and managed. Information was disseminated down to staff through staff meetings, safety huddles and newsletters. Staff reported they were invited to attend governance meetings but had not felt the need to attend as they felt their thoughts and opinions were already valued and listened to.
- Outpatient managers attended monthly outpatient meetings where good practice and learning was shared. Although, at the time of the inspection the outpatient

manager's post was vacant, staff reported the previous manager had been very visible and there had been more direction for the development and sharing of information within outpatients.

- There were effective arrangements in place to monitor and mitigate risks in a timely way. Overview of the risk register was managed at service level, and were managed and reviewed at governance meetings and were updated regularly. The acting outpatient managers were aware of the risk register and staff felt it reflected the concerns they had. The diagnostic imaging service had a divisional risk register which was sortable and contained assessments of risks including mitigating actions and ongoing monitoring. This identified a number of risks including concerns about the high turnover of radiographers and the numbers of agreed unreported images. The risks identified on the risk registers were aligned to those that managers identified as their main concerns, including radiologists, who said the unreported images 'did not sit well' with them. These images were discussed during the monthly meetings and prioritised accordingly. There was a plan in place to utilise reporting radiographers which would also free up radiologists.
- Regular auditing took place with evidence of improvement or trends. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results. This included the auditing of clinic utilisation.
- There was an effective governance framework to support the delivery of the strategy and good quality care which included a twice yearly Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) meeting which all radiation protection supervisors fed risk assessments into. We saw evidence of the minutes from these meetings where protocols were considered and changed in relation to risks.
- Leaders of the diagnostic imaging service demonstrated a good holistic understanding of performance, which took into account safety, quality, activity and financial information. Managers were realistic in the business cases they made for equipment and staff, and communicated this to the staff and managers told us this hopefully ensured some of their bids were approved with little adjustment.

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- There was a systematic programme of clinical and internal audit in the diagnostic imaging service, which had recently been reviewed as part of the preparations for ISAS accreditation submission.
- Clinical policies and guidelines were available for all staff via the hospital intranet system. Staff were able to show us how to access policies and guidelines and the electronic incident reporting system and said the systems worked well.

Leadership of service

- Leaders had the skills, knowledge, experience and integrity to manage the outpatients and diagnostic imaging services. During the last inspection in 2014 there was no overarching leadership of the outpatient department reported at service level. On this inspection we found there was good oversight through the role of the outpatient manager and development of the outpatient steering groups.
- Since our last inspection the appointment booking system had been developed and a manager of this service had been established. This service had been used to utilise clinic spaces, improve response time to patients and reduce the number of appointment cancellations and rate of patients not attending their appointment. The manager of this service worked well with the interim outpatient manager and attended the outpatient steering group meetings.
- Staff informed us leaders were visible and approachable. At the time of our inspection there was an outpatient's manager vacancy. However, staff reported the previous manager would attend and visit clinics as well as attending team meetings and the acting outpatients manager was approachable. Staff said they were respected and valued by their managers and they were always approachable and encouraged them to develop ideas. However, staff expressed concerns at some leaders' inconsistent approach to personal or sensitive issues.
- Within the radiology department we saw staff and teams worked collaboratively and senior staff took on the responsibility to train and mentor junior staff. For example, one member of staff oversaw the electronic competency framework used to record staff experience in modalities, and updated it every three months to

reflect how much time each member of staff had spent in the modality in the previous three months. In doing this, it was hoped the framework would help identify areas where staff needed extra training.

- Through the content of governance papers and talking with staff, we saw the leadership reflected the requirement to deliver safe, effective, caring and responsive and well-led services.
- Managers were mindful of the ongoing cost improvement programme and strove to deliver an efficient service as possible without affecting patient quality of care.

Culture within the service

- The culture centred on the needs and experiences of people who used the services. All staff we spoke with mentioned patient care was at the forefront of their and their manager's focus.
- Staff said they felt respected and valued and all staff were supportive and approachable. There were regular awards given to teams and individuals who had excelled. The cardiology department had recently been recognised as one of the happiest departments.
- All staff reported they felt listened to and their opinions and views were listened to. They said they were informed when the things they had requested could not be obtained and leaders worked with them to develop a new strategy to achieve their aim or goal and explained the reasons why. One staff member said, 'they never just say no, they always try to find a solution'. However, within the diagnostic imaging department staff told us they did not always feel respected and valued, and some staff felt they could be better used to help clear the reporting backlog.
- There was a culture of candour, openness and honesty within the service. Staff we spoke with reported they were encouraged to raise any issues or questions. We heard of incidences where staff challenged more senior peers on decision making and staff felt empowered and supported to do this.

Public and Staff engagement

- Staff and patients' views and experiences were gathered and used to shape and improve the services and culture. There were friends and family questionnaires and feedback forms in every clinic we visited. We were given examples from staff when things had changed as a

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result of patient feedback. This included the alteration of the way in which waiting times were displayed within the cardiology department following feedback from patients that they found the electronic board confusing.

- Staff reported they felt actively engaged so their views were reflected in the planning and delivery of the service and this helped shaped the service culture. Staff we spoke to felt as an outpatient service they felt more recognised and appreciated both at a departmental and trust wide level. One staff member said, “we are no longer seen as the departments that attract the waifs and strays”.
- All staff we met said they felt valued and part of the team. They said the outpatient division was an “enjoyable place to work” with a “diverse and interesting range of job opportunities.” Staff felt supported by the senior management team, heads of division and their colleagues. One member of staff said “people make the place ... people go beyond to step in to help colleagues.”
- Thank you cards were on display throughout the division to remind staff of their successes.
- There was a parking scheme for staff and a cycle to work scheme was promoted.
- Access to counselling was available for all staff through an employee assistance programme. This was a programme based around cognitive behavioural therapy and provided staff with an independent counselling service and a 24-hour advice line.
- An interactive web-based method had been designed, piloted and implemented to collect, act and report on real-time staff feedback. The “Happy-App” had been introduced in some areas to encourage staff to actively engage with managers to improve their working environment and standards of patient care. The Happy-App encouraged staff to express how they were feeling whilst they were at work. All staff could use the app, as many times as they liked during a shift, via a computer or iPad in their department. On the user home screen staff rated their current mood by selecting either a happy, neutral, or sad face. They then chose the category that most closely fitted the reason for their mood (e.g. equipment, team etc.) and wrote a comment explaining why they had picked that particular emotion. Local managers could log in to an administrator’s screen to see the mood of their staff in real-time and could respond to the comments. This allowed managers to understand the reasons why staff were feeling a

particular way and meant they could address and resolve issues raised by staff. The trust had recently won a National award for the introduction and use of ‘The Happy App’.

- The outpatients steering group had undertaken a project to improve the content and quality of patient letters. Patient’s views and opinions were used to shape the new letters and the most recent audit showed 98% of patients found the new letters easier to understand. The diagnostic imaging service actively engaged with patients, relatives and staff to involve them in decision making about the planning and delivery of the service. For example, a series of staff engagement meetings had taken place to help managers better understand their staff. As a result, five work streams had been developed which covered health, wellbeing, culture, communications, and leader development. Different managers within diagnostic imaging were leading on each work stream. Initial feedback from staff had been positive as staff had previously felt they had been left out of planning and decision making.
- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The results of the survey were used by departments to improve the service.
- Members of the public were also engaged with through the use of patient advisory groups. Patients who accessed the rheumatology service were engaged in a patient advisory group where discussion took place to ensure patients were involved in teaching, research and clinical care. The group met on a monthly basis.
- The surveys covered the patient’s overall satisfaction of experience and how likely they were to recommend the hospital to friends and family if they needed similar care and treatment. Comment cards and email feedback from patients had resulted in the alteration of the presentation in oncology clinics.

Innovation, improvement and sustainability

- Staff were clear their focus was on improving the quality of care for patients. They felt there was scope and a willingness amongst the team to develop services.
- Staff in the outpatients and diagnostic imaging services were able to give multiple examples of where developments had an impact on the quality of the service. In dermatology we were informed of the introduction of photodynamic therapy for superficial treatment of basal cell carcinomas, this would reduce

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the number of patients having to undergo surgery and thus also reduce surgery wait times. The outpatient steering group was in the process of developing a live tracker to improve clinic utilisation and accurate waiting times.

- The use of digital dictation within the outpatient departments had been introduced. We observed these within the restorative department of University of Bristol School of Oral & Dental Sciences. This had improved the speed in which letters were sent to general dental practitioners.
- The diagnostic imaging service had moved all of its equipment maintenance to their in-house, onsite engineering team. When new equipment was purchased, the department's own engineers went on a

training course alongside the equipment companies' own engineers, to learn how to service and maintain the equipment. This helped to reduce equipment down time and expenses.

- "Bright Ideas" was a regular competition to promote innovations which had the potential to improve patient care, and to identify and reward innovative individuals and teams within the trust. The competition encouraged innovation, stimulated safety and quality improvement ideas and provided help to get the best ideas off the ground. The competition invited staff to put forward innovative solutions to day-to-day challenges. Innovative ideas were invited from any area of the trust activity and were required to be original, feasible and have the potential to be re-applied in other areas of the trust.

Outstanding practice and areas for improvement

Outstanding practice

- In times of crowding the emergency department was able to call upon pre-identified nursing staff from the wards to work in the department. This enabled nurses to be released to safely manage patients queueing in the corridor.
- The audit programme in the emergency department was comprehensive, all-inclusive and had a clear patient safety and quality focus.
- New starters in the emergency department received a comprehensive, structured induction and orientation programme, overseen by a clinical nurse educator and practice development nurse. This provided new staff with an exceptionally good understanding of their role in the department and ensured they were able to perform their role safely and effectively.
- In the emergency department the commitment from all staff to cleaning equipment was commendable.
- The comprehensive register of equipment in the emergency department and associated competencies were exceptional.
- Staff in the teenagers and young adult cancer service continually developed the service, and sought funding and support from charities and organisations, in order to make demonstrable improvements to the quality of the service and to the lives of patients diagnosed with cancer. They had worked collaboratively on a number of initiatives. One such project spanned a five year period ending May 2015 for which some of the initiatives were ongoing. The project involved input from patients, their families and social networks, and healthcare professionals involved in their care. It focused on key areas which included: psychological support, physical wellbeing, work/employment, and the needs of those in a patients' network.
- The use of technology and engagement techniques to have a positive influence on the culture of an area within the hospital. There were clear defined improvements in the last 12 months in Hey Groves Theatres.
- The governance processes within the division to ensure risks and performance were managed.
- The challenging objectives in the strategy and how they are used to proactively develop the quality and the safety of the service.
- The use of innovation and research to improve patient outcomes and reduce length of stay. The use of a discrete flagging system to highlight those patients who had additional needs. In particular those patients who were diabetic or required transport to ensure they were offered food and drink.
- The introduction of IMAS modelling in radiology to assess and meet future demand and capacity.
- The use of in-house staff to maintain and repair radiology equipment to reduce equipment down time and expenses.
- The introduction of a drop in chest pain clinic to improve patient attendance.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure all medicines are stored correctly in medical wards, particularly those which were observed in dirty utility rooms.
- Ensure records in the medical wards and in outpatient departments are stored securely to prevent unauthorised access and to protect patient confidentiality.
- Ensure all staff are up to date with mandatory training.

- Ensure non-ionising radiation premises in particular Magnetic Resonance Imaging (MRI) scanners restrict access.

Action the hospital **SHOULD** take to improve

- Ensure chemicals are stored securely at all times in the emergency department and on medical wards.
- Ensure checks of the equipment in the emergency department's resuscitation area are recorded consistently.

Outstanding practice and areas for improvement

- Ensure patients in the emergency department have access to call bells at all times.
- Ensure reception staff are able to recognise patients who attend the emergency department with serious conditions need urgent referral to the triage nurse and provide a formalised process for summoning help.
- Continue working towards providing 16-hours on-site consultant cover in the emergency department, and increase consultant cover at the weekend.
- Ensure the emergency department is accessible to wheelchair users and the layout of the reception desk allows staff to interact with wheelchair users whilst sat at the desk.
- Ensure the emergency department develops and formalises its vision and strategy.
- Ensure staff in the emergency department are up-to-date with their mandatory training, including safeguarding adults and children.
- Work with commissioners and the local mental health service provider to ensure mental health patients arriving at the emergency department receive the care they require in a timely manner.
- Ensure all staff working in the emergency department and medical staff receive an annual appraisal.
- Ensure clear signage and equipment is in place for staff, patients and visitors to wash their hands when entering a medical ward area.
- Ensure the environment in the oncology department and ward keeps patients safe and comfortable, especially for patients who may be confused or cannot maintain their own safety.
- Ensure access to the staff room on the medical assessment does not allow access to unauthorised people.
- Take remedial maintenance action to ensure the heating system on ward D703 maintains a suitable and safe temperature for staff and patients.
- Ensure staff have a greater understanding and awareness of the intercom system on the Hepatology ward, to ensure safe and prompt access to the ward and confidentiality of patient information.
- Ensure medical doctors' inductions are undertaken in scheduled blocks and planned so doctors do not start work on the wards without an induction.
- Ensure clear signage and equipment is in place on medical wards to advise staff, patients and visitors to wash their hands when entering a ward area.
- Ensure delays in take home medicines does not delay patients.
- Ensure medical records are legibly and fully completed. This includes patient risk assessments.
- Audit records in the cardiac catheter laboratory to ensure they are fully compliant with the World Health Organisation surgical safety checklist for all surgical procedures.
- Address the risk in the acute oncology service where patients may be placed at risk by reduced staffing levels at night due to admissions of emergency oncology patients. There should be suitably skilled staff in place at night to ensure safe triage advice is given to patients accessing the emergency oncology service. Whilst the trust recognised these risks, sufficient action should be taken to minimise the risk to patients in both the service provision and staffing provision.
- Ensure pain audits are established to monitor if pain was managed effectively for patients with an ability to express their pain.
- Continue to monitor staff's use of the Abbey Pain Scale to ensure patients with cognitive impairment in the specialised services division have an effective tool to assess their pain needs.
- Continue to ensure all efforts be made to maintain flow through the hospital and patients be nursed on the correct wards to meet their needs.
- Reduce the risk on the hepatology ward in relation to lone working practices, when accompanying patients off the ward at night to smoke.
- Improve the level of safeguarding training for staff working overnight in the surgical trauma assessment unit.
- Improve compliance for mandatory training in surgical areas.
- Improve patient outcomes to bring them in line with the national average for the hip fracture audit and improve the National Emergency Laparotomy Audit.
- Ensure patients within all of the diagnostic imaging waiting rooms can be monitored by staff.
- Monitor the World Health Organisation (WHO) Surgical Safety Checklist is always used in the appropriate area as a checklist when carrying out non-surgical interventional radiology.
- Provide leaflets within outpatient departments are available in different languages

Outstanding practice and areas for improvement

- Check local and national diagnostic reference levels (DRLs) are on display as stated in Regulation 4(3)(c) of IR(ME)R 2000 and IM(ME) amendment regulations 2006 and 2011.
- Make improvements on the follow up backlog waiting list to meet people's needs and minimise risk and harm caused to patients through excessive waits on follow up of outpatient appointments and the reporting of images.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must maintain securely at all times records in respect of each service user. These should only be accessed and amended by authorised people.

Records within cardiology, dermatology and outpatient departments were not always kept in locked containers.

Regulated activity

Diagnostic and screening procedures

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

2 (d) The provider must ensure premises used by the service provider are safe to use.

Patients within the radiology department could access unlocked Magnetic Resonance Imaging (MRI) rooms

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12(2)(g) the proper and safe management of medicines.

- There was not always proper and safe management of medicines with sluices being used to store some creams and treatments. The sluice rooms were not an appropriate area for storage.

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations
2010 Supporting staff

The provider had failed to have suitable arrangements in place to ensure all medical staff were supported to receive fire training, resuscitation training and safeguarding training to enable them to be prepared should an event occur.